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PARAPROFESSIONALS IN COMMUNITY MENTAL HEALTH: ATTITUDES, ATTITUDE CHANGE, AND ATTITUDE STABILITY

by

Myrtle B. Sampson

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Approved by

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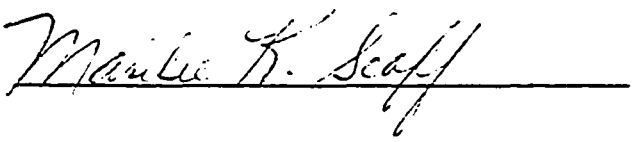
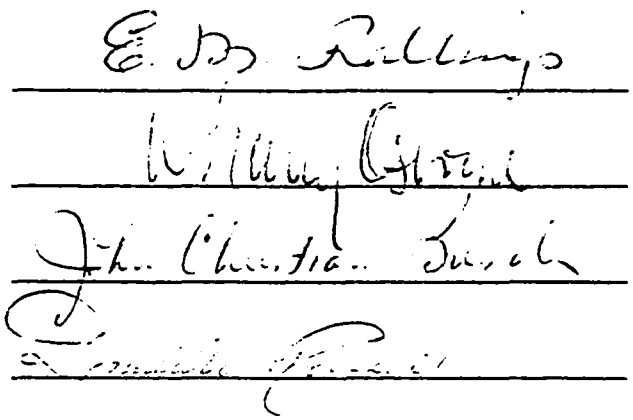
APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of the Graduate School at the University of North Carolina at Greensboro.

Dissertation Adviser 

Committee Members 

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SAMPSON, MYRTLE B. Paraprofessionals in Community Mental Health: Attitudes, Attitude Change, and Attitude Stability. (1976) Directed by: Dr. Marilee K. Scaff. Pp. 268.

The aims of this study were to investigate the attitudes of paraprofessional trainees toward mental illness, work in community mental health, and their attitudes toward professionals in the area. Related to these aims, questions were also raised concerning the interaction of Self Concept with attitudes, attitude change and attitude stability.

A pilot study with 27 paraprofessional trainees from North Carolina Agricultural and Technical State University developed a research instrument for assessing the attitudes toward work and professionals in community mental health and attempted to change the Self Concept of the paraprofessional trainees by 100 clock hours of practicum experiences.

The research sample consisted of 48 paraprofessional trainees at Wayne Community College and 45 paraprofessional trainees at Western Piedmont Community College. Subjects were randomly divided into four treatment groups based on self concept scores using the Tennessee Self Concept Scale. Two other research instruments were administered as pretests: the Opinion About Mental Illness Scale and the Attitude Toward Work and Professionals Scale. Using scores on the Tennessee Self Concept Scale, subjects were divided into three pools, High Positive Self Concept, Average Self Concept, and Low Negative Self Concept, and randomly assigned to four treatment groups.

The four levels of the Treatment Program that is, contact only, information only, contact-plus-information, and control, were also randomly assigned to groups. Subjects in the contact only group spent

10 hours at a psychiatric hospital interacting with the patients in recreational, occupational, music, and industrial therapies. For 10 hours, the subjects in the information only group were exposed to taped lectures, live lectures, films, and pamphlets presenting the positive attitudes individuals should develop toward mentally ill patients, work, and professionals in community mental health. The subjects in the contact-plus-information group spent 5 hours at the psychiatric facility with the contact only group and 5 hours at the college with the information only group. The subjects in the control group engaged in group activities and were exposed to materials on communication modules, reality therapy, and transactional analysis.

Twelve hypotheses were explored: four for each dependent variable dealing with the Self Concept, Treatment Program, interaction of the Self Concept and Treatment Program, and the interaction of the Self Concept, Treatment Program, and Time, as related to attitudes toward mental illness, attitudes toward work, and attitudes toward professionals. A three factor analysis of variance analyzed the main effects and interactions of three independent variables: Self Concept, Treatment Program, and Time. A four factor analysis of variance was also analyzed, using Race as the fourth variable at Wayne Community College where the ratio of Black to White subjects in the population was 50:50.

Major findings of this study were:

1. Various positive and negative relationships were found with the Self Concept and methods of treatment as related to attitudes toward mental illness, work, and professionals.

2. Contact and information experiences were effective methods of Treatment for some Self Concept groups for positive directional attitude change toward mental illness, work, and professionals in community mental health.

3. All subjects became increasingly more negative in their attitudes toward professionals over the three testing periods.

4. All Self Concept groups decreased on Authoritarianism and Social Restrictiveness dimensions, and increased on the Benevolence and Mental Hygiene Ideology dimensions on the OMI at some point in time over the three testing periods, but not in a constantly linear direction.

5. There was a positive change in the Self Concept after a practicum experience of 100 clock hours in the pilot study.

Several topics for further research are the following: the interrelationships of attitudes and the interrelationships between attitudinal dimensions and behavior; major factors in the environment that influence the stability of attitudes; the effectiveness of different types of information and contact on attitude change and attitude stability; nature of components relative to negative attitudes toward professionals; and methods of facilitating positive changes in Self Concept within a short period of time, and of maintaining stability of changed attitudes.

These recommendations for future research are made with the expectation that they would provide important new information about attitudes, attitude change, and attitude stability.

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CHAPTER I

FORMULATION AND DEFINITION OF THE PROBLEM

Contemporary society has evidenced an increasing awareness of the quality of life of its citizens, and one area of special concern has been provision for improved physical health and mental health. It is estimated that 19,000,000 Americans suffer from mental illness. Five million alcoholics need treatment. Accurate figures on drug addiction are constantly revised, but national research reports continued drug usage, and though present studies indicate a slight decrease in drug use among high school and college students, they show an increase in alcohol consumption (Blum, 1970; NIMH, 1974; Weiner, 1976; Wertheimer, 1970).

Despite the increased concern for mental health services, existing personnel, both professional and paraprofessional, are inadequate in numbers and ability to serve all those needing help, especially among the poor. Clearly, the solution to the problem does not lie in massive increase of hospital facilities and care. While electroconvulsive shock treatment and improved results with chemotherapy have given new hope for one "incurable" mental illness, short-term therapeutic intervention and community-based outpatient services offer fresh solutions to the problem of provision of mental health services for all people.

Community mental health objectives include provision of those essential community resources which would serve as a first line of

defense against mental illness. A comprehensive program would link service elements to assure continuity of care, provide for the total population of a specifically defined area, and establish and maintain preventive as well as remedial services (National Institute of Mental Health, 1973).

The critical question is, however, "Who will give the psychotherapy and carry out the social rehabilitation for which the mentally ill are ready?" (Gorman, 1970). Recent studies have clarified several points: professional manpower is inadequate (Albee, 1959); availability as well as effectiveness of helping operations must be extended (Cowen, 1967); and community mental health might augment professional services by the use of paraprofessionals. Levinson and Reiff (1970) estimated that 42% of the staffs of community mental health centers in several cities and regions were composed of paraprofessionals, and believed the percentage to be increasing. As paraprofessionals become important agents in the delivery of community mental health services, it is necessary to consider who they are, their attitudes toward mental illness, toward community mental health services, and toward professionals in the area, in order to utilize their services in the most effective way.

Community Mental Health

A Joint Commission on Mental Illness and Health was established in 1955. In his February 3, 1963, message to Congress, President John F. Kennedy called for a "bold new approach" to mental illness: a network of community mental health centers. Although neither the Joint Commission's report nor President Kennedy's message was universally acclaimed,

the United States Congress passed the Community Mental Health Centers Act of 1963 (Title II of Public Law 88-164) which provided up to two-thirds of the funds necessary for construction of facilities for comprehensive coordinated mental health programs within communities.

The goals of community mental health are relatively simple and clear (Roen, 1971): to rehabilitate the mentally ill, to treat them in their communities, if at all possible, and to formulate and emphasize more prophylactic measures in the environment.

Paraprofessionals' Attitudes Toward Mental Illness

As community mental health programs developed, a lack of adequate personnel hampered the attempt to offer more and better services. Programs training paraprofessionals profilerated, attempting to meet two social needs: the enormous demand for mental health services, and the special need for employment of the economically less privileged groups in the community (Gartner, 1971; Karno & Schwartz, 1974). Even though many paraprofessionals were recruited from the population to be served, there was also a representative number from different social classes and social groups. Individuals from the lower and middle socio-economic classes have been more likely to have negative attitudes toward the mentally ill (Dohrenwend & Chin-shong, 1967). Gartner (1971) found that two-thirds of the paraprofessionals were from minority groups, had a high school education or less before beginning the training program, and were in the 30-plus age group. Thus these paraprofessionals came largely from the very groups whom Hollister and Edgerton (1969) found had relatively high stigma scores in reference to mental illness; that

is, from non-white, older, poorly educated, low occupation and income status persons.

Baker and McPheeters (1975) made the only study which has described the attitudes of the new type of paraprofessionals as a group, about which this research is concerned. That study dealt with the personality characteristics, motivations and attitudes of the paraprofessional trainees in seven different associate degree training programs. This study, as well as other research, has shown that people in general and in categorized groups (i.e., nurses beginning psychiatric training, volunteer college students, and traditional-type aides), have less favorable attitudes toward the mentally ill (Altrocchi & Eisdorfer, 1961; Chinsky & Rappaport, 1970; Hicks & Spaner, 1962; Kulik, Martin, & Scheibe, 1969; Quay, Bartlett, Wrightsman, & Catron, 1961; J. Smith, 1969).

The Joint Commission on Mental Illness and Mental Health made a detailed study (1961) and reported ambiguous social attitudes toward the mentally ill: in principle, "well people" would like to have the mentally ill treated humanely, and if possible, in a manner that enables them to recover. In practice, however, the public still tends to subscribe to the less favorable attitudes toward the mentally ill. Other research studies supported this view; when a person is or has been mentally ill, society tends to reject him (Chin-shong, 1968; Clausen, 1959; Crocetti, Spiro, & Siassi, 1974; Cummings & Cummings, 1957; Edgerton & Bentz, 1969; Freeman, 1960; National Institute of Mental Health, 1973; Nudelman, 1965; Nunnally, 1961; Star, 1955). On the other hand, approximately an equal number of studies have found that the public has

become enlightened and accepting in their attitudes toward the mentally ill (Anthony, 1972; Bentz, Edgerton, & Kherlopian, 1969; Crocetti et al., 1974; Edgerton & Hollister, 1973; Lemkau, 1965; Spiro, Siassi, & Crocetti, 1974; Szasz, 1961).

Ambivalence in many persons' attitudes may account for the diversity in results. Other possible reasons for discrepancies were stated by Crocetti et al. (1974): research reports are scattered diffusely through the literature, so that mental health professionals are unaware of the cumulative impressions of increasingly positive attitudes toward the mentally ill. Furthermore, the discrepancies among studies may result from the fact that the operative definition of mental illness for the public is still a stereotype of violent, assaultive behavior.

Paraprofessionals' Attitudes Toward Their Work and Professionals

Very few studies have described the attitudes of paraprofessionals toward their work and toward professionals in mental health. Opinions of both professionals and paraprofessionals have been voiced. Some of these opinions and brief comments from a few of the studies will be mentioned now and elaborated upon in Chapter II.

Attitude Toward Work

Patino (1972) conducted a study to determine the difference in attitudes between professional and paraprofessional workers in state service centers. The focus was on their attitudes toward work, co-workers, and promotions, people in general, and their perceptions

toward low income consumers. He supported five hypotheses. Professionals, in comparison to paraprofessionals, placed significantly lower in their trust and faith in other people. Another null hypothesis rejected was: "There will be no significant difference between paraprofessionals and professionals in their attitudes toward fellow workers" (p. 127). The professionals in their attitudes toward fellow workers scored significantly higher, that is, more positive in attitude, than did the paraprofessionals.

Attitude Toward Professionals

Paraprofessionals have expressed frustration in regard to professionals' perceptions of them. A substantial minority of paraprofessionals feel that some professionals "look down" on them, consequently they are wary of professionals; and both groups show negative attitudes toward each other (Gottesfeld, Rhee, Parker, 1970; Sobey, 1970).

The Self Concept of Paraprofessionals

An individual's self concept plays an important role in his life (Berkowitz, 1969; Borgatta & Lambert, 1968; Newcomb, Turner, & Converse, 1965; Wylie, 1974). If that self concept is negative or inadequate, the person will tend to lack self-confidence, to distrust others, and to restrict personal contacts and activities. Low self-esteem may manifest itself either as undue modesty or boastfulness. Many persons of low self esteem also show inconsistency in self concept (Berkowitz, 1969).

According to the self-other congruence principle, when the attitudes of other persons are congruent with one's own attitudes, one's

reactions are positive; when there is incongruence in attitudes, one's reactions are negative (Newcomb, Turner, & Converse, 1965). An obvious result is that an individual will tend to have positive attitudes toward those whom he perceives to have positive attitudes toward him, and negative attitudes toward those who appear to evaluate him negatively.

Paraprofessionals' work enhances their self concepts. The Minneapolis New Careers Program found significant changes in the self concept of their paraprofessionals in a positive direction (1969). However, more research needs to be done in this area to validate these findings.

Job Attitude and Job Performance

Herman (1973) states that empirical data demonstrate that when behavioral alternatives are not structured by situational constraint, job attitudes predict job performance. As the role of the paraprofessional has not been clearly conceptualized (Karno & Schwartz, 1974), possible negative attitudes of some paraprofessionals toward mental illness, their work, and professionals are very important, since negative attitudes have been found to result in negative behavior and performance (Anthony and Carkhuff, 1970; Canter, 1963; Rokeach, 1972; Rosenberg & Hovland, 1960; Triandis, 1971).

Attitude Change

Attitudes of significant others have important implications for a person's well-being and satisfaction (Mills, 1972). As this idea is generally accepted by most social scientists, and some empirical

evidence shows the relationship between attitudes and behavior, efforts have been made to change negative attitudes when they have had adverse effects on job performance.

Contact

One method designed to induce attitude change is to arrange contacts between groups from the general public and members of a disabled group (Cowen, Underberg, & Verrilo, 1958; Gaier, Linkowski, & Jacques, 1968; Jaffe, 1967; Semmel & Dickson, 1966; Yuker, Block, & Young, 1966). Studies investigating the contact dimension have used one or two approaches. One method, ex-post-facto research, divides the subjects into groups on the basis of their self-reports about the amount of contact they have had with a member of a disabled group to determine if differences exist in the attitudes of subjects differing in the amount of self-reported contact.

The second method, experimental design, exposes the subjects to a specific contact experience and assesses the effects of this observed contact experience on the subjects' attitudes. Extensive literature exists on both methods (Anthony & Cannon, 1969; Centers & Centers, 1963; Cowen, Underberg, & Verillo, 1958; Gaier, Linkowski, & Jacques, 1968; Semmel & Dickson, 1966; Winer, 1971; Yuker, Block, & Young, 1966).

Results of studies using the self-reported contact do not agree. Non-significant results and also significant differences showing both negative and positive effects of contact on attitudes have been found. Some experimental contact studies showed it was possible to change attitudes by contact, but this finding was not supported with regard

to attitudes toward disabled persons (Anthony & Cannon, 1969; Centers & Centers, 1963; Granofsky, 1966; Lapp, 1957; Rucker, Howe, & Snider, 1969; Stauch, 1970). Retrospective contact studies were methodologically deficient in several important ways which may account for their conflicting results. First, the individual subject defines what is meant by contact, and the type of contact probably varies from subject to subject. Second, the contact experience for many subjects may have contained informational components as well, and the independent effects of contact and information could not be isolated.

In summary, a limited number of experimental studies on the effects of contact have not agreed upon the question whether contact in and of itself significantly changed attitudes toward persons with a disability.

Information

Attempts also have been made to change attitudes by providing the nondisabled persons with information about disabled people. This information may take the form of a book, a course, a lecture or discussion, a film, or an institutional tour. Sarbin and Mancuso (1970) found that information alone was negligible in producing positive attitude change. Several other studies corroborated these findings (Altrocchi & Eisdorfer, 1961; Chinsky & Rappaport, 1970; Cleland & Chambers, 1959; Costin & Kerr, 1962; Semmel & Dickson, 1966; Staffieri & Klappersack, 1960). However, the untested possibility remains that the information alone presented by the professional was faulty and that some other kind of information would be effective in facilitating attitude change (Anthony, 1972).

Contact-Plus-Information

Some research has attempted to change attitudes toward disabled individuals by combining the contact experience with some type of information about the disability. The findings of these studies appear to be more consistent. Regardless of the type of disability studied, and seemingly independent of the type of contact and information experience provided, five studies have reported that contact-plus-information had a favorable impact on the nondisabled person's attitude (Anthony, 1969; Anthony & Carkhuff, 1970; Chinsky & Rappaport, 1970; Rusalem, 1967; J. J. Smith, 1969).

In summary, the attitude of nondisabled persons toward persons with a disability was influenced positively by providing the nondisabled individual with an experience which included contact with disabled persons and information about the disability. However, neither contact nor information alone was significant and consistent in securing a favorable attitude change toward disabled persons.

Attitude Stability

The term balance is commonly applied to the terms cognitive dissonance and consonance (Festinger, 1957). When two or more things are in balance, their relationships to each other tend to remain stable. Balanced relationships remain as they are until new influences upset the balance, while relationships that are not in balance are forced to change. The usefulness of the notion of balance is not merely that it provides a synonym for the notion of stability, but rather it provides a challenge to seek the conditions under which a relationship remains

stable or balanced. The problem of how a person's attitudes are organized is really a problem of stable organization (Newcomb et al., 1965).

The general conditions under which different attitudes of the same person are stably related to each other, under which they can peacefully coexist, are described by the principle of balance; attitudes toward objects viewed as belonging together tend to become congruent. Congruence is a balanced condition, and as long as it is maintained for an individual, his attitudes tend to remain stable. Change does not tend to occur without some input of new information or experience, which is equivalent to saying that if nothing happens to induce change there will be no change (Rosenberg, Hovland, McGuire, Abelson, & Brehm, 1960). When some influence does induce change, a new state of balance will be developed (Newcomb, 1965). The idea of balance applies not to a single attitude but to relationships between two or more attitudes.

The principle of balance does not apply to all of a person's attitudes, in the sense that all of them are in balance with each other: it applies to particular sets of attitudes that show some interdependence. The key facts of attitude stability are that a person's attitude toward something is imbedded in a larger network of attitudes, that such things as the amount of stored information about the object, its personal goal relevance and psychological centrality are all indicators of such imbedding. Any attempt to change an attitude must come to grips with the fact that this attitude is anchored by other attitudes in a system; when one is changed, then other compensatory changes must follow to restore balance. More effort is required to produce changes in

attitude systems than would be required to change an "isolated" attitude. Therefore, if an individual has a negative attitude toward an object or idea which is interconnected with other ideas, he will probably possess negative ideas toward the related objects or ideas. However, if the negative idea shifts toward the positive realm, then there should be a corresponding shift in related ideas.

This research, in attempting to influence attitudes of paraprofessionals toward persons who are mentally ill, toward professionals, and toward their work, must take into account the interrelationships of these attitudes in a total system of attitudes. Whether or not attitude change can be effected by a treatment mechanism and whether such changes will be retained over time are questions to which this research will address itself.

Statement of the Problem

The specific foci of this study concern the attitudes of paraprofessionals with positive and negative self concepts toward mental illness, their work, and professionals, and possible change of attitudes in these areas in a more positive direction. Paraprofessionals beginning their training program were divided into three treatment groups, plus a non-treatment control group. Attitudes of all group members toward mental illness, their work, and professionals were assessed before the treatment program, after the experimental groups were subjected to the treatment, and again, after a period of eight weeks in order to determine the stability of any attitude shift that may have occurred.

Three variables were investigated in the study: (a) self concept, with three levels (high positive, average, and low negative); (b) attitude change mechanism as treatment, with four levels (contact, information, contact-plus-information, and control); and (c) time of testing (pretest, posttest, and delayed posttest).

The independent variable, self concept, was measured by the Tennessee Self Concept Scale. The dependent variables, attitude toward mental illness, attitude toward work, and attitude toward professionals, were assessed by the test instruments Opinions About Mental Illness Scale and Attitude Toward Work and Professionals Scale. Details about the construction, validity, and reliability of these scales will be discussed in Chapter III.

Hypotheses

For clarity, the hypotheses are grouped according to the three different dependent variables of the study. In consideration of the conflicting evidence from the literature, they are all stated in the null form. The hypotheses were tested by the appropriate *F* value in the analysis of variance and subsequent individual comparisons.

Attitude Toward Mental Illness

1. There will be no significant difference in attitudes toward mental illness between subjects classified as high positive self concept, average self concept, and low negative self concept.

2. There will be no significant difference in attitudes toward mental illness between subjects exposed to the four levels of treatment (attitude change mechanism).

3. There will be no significant difference in attitudes toward mental illness due to the interaction of the effects of levels of treatment (attitude change mechanism) and self concept of the subjects.

4. There will be no changes in attitudes toward mental illness over time of measurement due to the interaction of the effects of levels of treatment (attitude change mechanism) and self concept of the subjects.

Attitude Toward Work

5. There will be no significant difference in attitudes toward work between subjects classified as high positive self concept, average self concept, and low negative self concept.

6. There will be no significant difference in attitudes toward work between subjects exposed to the four levels of treatment (attitude change mechanism).

7. There will be no significant difference in attitudes toward work due to the interaction of the effects of levels of treatment (attitude change mechanism) and self concept of the subjects.

8. There will be no change in attitudes toward work over time of measurement due to the interaction of the effects of levels of treatment (attitude change mechanism) and self concept of the subjects.

Attitude Toward Professionals

9. There will be no significant difference in attitudes toward professionals between subjects classified as high positive self concept, average self concept, and low negative self concept.

10. There will be no significant difference in attitudes toward professionals between subjects exposed to the four levels of treatment (attitude change mechanism).

11. There will be no significant difference in attitudes toward professionals due to the interaction of the effects of levels of treatment (attitude change mechanism) and self concept of the subjects.

12. There will be no changes in attitudes toward professionals over time of measurement due to the interaction of the effects of levels of treatment (attitude change mechanism) and self concepts of the subjects.

Significance of the Problem

This study will contribute to a knowledge of attitude change in a broad age group. Previous studies in this area have investigated attitudes primarily with students in college or high school seniors (Altrocchi & Eisdorfer, 1961; Chinsky & Cochran, 1961; Holzberg & Gerwirtz, 1964; Jaffe, 1971; Keith-Spiegel & Spiegel, 1970; King, Waller, & Pavey, 1970; Kulik, Martin, & Scheibe, 1969; Rokeach, 1971; J. Smith, 1969). The subjects in this study fall within the age range of 18 to 53, with a median age of 25.4 years. Forty percent of them were married and had one or two children, and 65% had held at least two or three jobs previously. The results of this research may then be applicable to a greater range of the population because of its different sample parameters.

As a result of this investigation, professionals training community mental health workers will have more knowledge on which to design personnel development programs in hospitals and to strengthen curricula for training paraprofessionals. Several studies in the literature have been conducted employing contact or information, but very few studies to date have been conducted using contact-plus-information.

Applicability is also enhanced because the element of "volunteering" inherent in many studies is eliminated. All students in the selected training programs were required to participate in this

investigation as part of their regular studies. As these are innovative and experimental programs, required participation in all activities was explained to students before they enrolled.

The changing of attitudes over time should increase the knowledge pertaining to attitude studies in this area and provide some additional insights into opinions about mental illness. A study of this type has not been done with paraprofessionals, and only Altrocchi and Eisdorfer (1961) have researched attitude change toward mental illness using a delayed posttest differential.

No study has attempted to assess the attitudes of paraprofessionals toward mental illness, their work, or professionals as they relate to the self concept. Therefore, this information should prove to be very enlightening in the area of community mental health. Only four empirical studies have researched the attitudes of professionals toward paraprofessionals and the attitudes of paraprofessionals toward professionals (Baker & McPheeters, 1975; Douthit, 1971; Hartl, 1972; Sobey, 1970). These studies assessed attitudes, but did not attempt to influence attitude change. Hopefully, the findings from this investigation will enable interested persons in the area of community mental health to deal with attitudes from a more scientific perspective.

Little is known about how much time is needed to change attitudes. In recent research, the length of time ranged from 6 hours to 2 years. J. Smith (1969) postulated that attitude change occurs early in a semester, long before a contact-plus-information experience. Rusalem (1967) was able to bring about change toward the deaf-blind in only six hours, a

finding which suggests that an extremely short but intensive contact-plus-information experience is capable of producing favorable attitude change. Rokeach (1971) changed "values" in a period of 45 minutes by using a different definition and measurement of Festinger's (1957) theory of cognitive dissonance. Rokeach stated that "in a sense, values are the source and foundation of attitudes and behavior toward specific events, people, or situations" (Rokeach, 1971, p. 70). Because of the curriculum at each school this study used a 10-hour time period.

Research pertaining to the paraprofessional in any area, at this time, should assist professionals and society in evaluating their utilization and effectiveness.

Assumptions and Limitations of the Study

The following limitations apply to this study. The sample used in the study was not representative of the population at large. Therefore, generalization of findings is limited to paraprofessionals in similar settings as represented by the parameters of this study and possibly to other groups of similar backgrounds in training for the helping professions.

A large number of the subjects of this study came from groups designated by Edgerton and Hollister (1973) as having high stigma scores toward mental illness. This fact may have influenced the attitude change which was recorded by causing subjects with negative attitudes to become more positive.

Cultural and/or ethnic differences between populations in the two settings may influence results; hence they have been analyzed separately.

If self concept is enhanced it should result in improved job performance. Also, subsequent practicum experiences may have more positive results while the subject is a trainee in the community mental health program.

Delayed posttesting may be influenced by the curriculum of the training program in the time elapsing between it and the posttest so that differences between treatment groups may be obscured. But data were analyzed separately so differences in curriculum in training programs do not confound the treatment effects.

Definition of Terms

For the purpose of this study, the following terms were used as defined below.

Paraprofessional -- Individuals with at least a high school diploma or its equivalent (i.e., GED), enrolled in a degree program (Associate or B.S.) in community mental health without previous experience in the area.

The Attitude Toward Work and Professionals Scale was employed in the assessment of paraprofessionals' attitudes in areas designated by the title of the instrument.

Professional -- Physicians, psychologists, psychiatrists, psychiatric social workers, psychiatric nurses, or others with a degree or training above the bachelor level, working in the area of community mental health.

Community Mental Health -- A mental health services area which may be a segment of a large city, entire metropolitan area, a large rural area or an entire state (Gorman, 1970).

Attitude -- An individual's tendency or predisposition to evaluate an object or symbol of that object in a favorable or unfavorable way (Insko & Schopler, 1972; Mills, 1972; Osgood, Succi, & Tannebaum, 1957).

In this study, attitudes toward mental illness were measured by the Opinions About Mental Illness scale.

Mental Illness -- A condition of mental instability or pathology officially diagnosed by a psychiatrist, psychologist, or other certified person(s) in the helping professions (American Psychiatric Association, 1975).

Self Concept -- The self as perceived and known to the individual (Newcomb, Turner, & Converse, 1965). It is the person's total appraisal of his appearance, background and origins, abilities and resources, attitudes and feelings which culminate as a directing force in behavior. How a person behaves is the result of how he perceives the situation and himself at the moment of his action (Sherif & Cantril, 1947). An assessment of the self concept was made with the Tennessee Self Concept Scale.

Contact -- The act of being in touch physically, cognitively, or associating with another in the same environment; engaging in some activity together; specifically, for this study, contact with patients in a psychiatric hospital.

Summary

The remainder of this study will conform to the following format. Chapter II will contain a selected review of the literature about the attitude of the public toward mental illness, attitudes and attitude change, and the self concept as it affects acceptance of others and job performance and social behavior.

Chapter III will discuss methods and procedures of this research study. Specifically, attention will be given to the locale of the population sample and demographic characteristics, experimental design, and procedure of treatment in three phases: Phase I: initial assessment of attitudes and self concepts; Phase II: treatment program and reassessment of attitudes; and Phase III: delayed time posttest period. Methods for analyzing data will also be presented.

Chapter IV presents the findings of the study including basic data, the results of hypotheses testing, and the specifications of other significant relationships found in this investigation.

Chapter V discusses the findings.

Chapter VI summarizes the results and cites implications for future research.

CHAPTER II

REVIEW OF THE LITERATURE

The American public has very few choices if it wants to care for the untreated mentally ill, and must consider alternatives to professional personnel as they now exist. The most promising alternative has been the increasing employment of paraprofessionals.

In preparation for this research study, a computer search was made through the National Institute of Mental Health in Rockville, Maryland, on paraprofessionals in community mental health services and public attitudes toward mental illness. The usual University Reference Library sources were also checked. The Library of Congress supplied a bibliographical list of research on rehabilitation psychology. Several dissertations on professionals and paraprofessionals and attitudes toward each other and toward mental illness were purchased through University Microfilms of Ann Arbor, Michigan. The literature related to this dissertation was collected and studied from all these sources.

The review of the literature pertinent to this research covers three main areas: 1) literature on the attitudes of the public toward mental illness, 2) literature on attitudes and attitude change, 3) literature on the self concept.

Literature on the Attitudes of the Public Toward Mental Illness

All individuals are vulnerable to stress. For some groups, life has offered few opportunities to build resistance to physical or emotional stresses which arise both from the environment and from within the individual. Man is a social animal; and, to him, mental illness is no less universal than physical illness. Should not awareness of this personal vulnerability to mental illness evoke feelings of tolerance, understanding, and compassion, whether the illness be physical or mental?

Although research into public attitudes toward the mentally ill is relatively new, researchers have already become polarized toward two contrasting points of view: some have described the public as rejecting the mentally ill, displaying hostility, and closing ranks toward them; others have found society to be generally accepting of the mentally ill, compassionate toward them, and willing to accept them into their ranks (Crocetti, Spiro, & Siassi, 1974).

Most such studies have been surveys which sought to measure the individual's knowledge of various aspects of mental illness and the desire to maintain social distance between oneself and the mentally ill.

The idea of social distance, first used by Bogardus (1925), was later employed to study responses to ethnic groups. Allen (1943) first applied the concept of social distance to mental illness and found that fear, stigmatization, and rejection characterized public feelings. Ramsey and Siepp (1948) concluded, however, after World War II, that the public was moving toward a more humanitarian and scientific view of mental illness.

Most influential of the early studies was the 1950 national survey conducted by Star at the National Opinion Center of the University of Chicago. A complete report of Star's results was never published, but she did give talks on her findings to the National Association for Mental Health in 1953 and to the Association for the Advancement of Public Opinion Research in 1957.

"The Dilemma of Mental Illness," as the study was titled, was based on interviews with 3,500 individuals in a national quota sample. Six case descriptions of mentally ill people constituted one of the key parts of the interview: Frank Jones, a paranoid schizophrenic; Betty Smith, a simple schizophrenic; George Brown, a chronic anxiety neurotic; Mary White, a compulsive phobic; Bill Williams, an alcoholic; and Bobby Gray, a twelve-year-old child with a behavior disorder.

The respondents were asked a series of questions after being presented with each case: "Did you think anything wrong with the person so described? What is wrong? Is it mental illness? Is it serious? (Star, 1950, p.48)." Star concluded that only the paranoid schizophrenic was recognized by a majority of the sample as mentally ill. From this, she inferred that the public perceived only extreme psychosis accompanied by threatening, assaultive behavior as its definition of mental illness.

In a round table discussion at the American Psychiatric Association in 1950, Bingham expressed the idea that the public's concept of psychiatry came from its misconception of psychiatrists, an erroneous view derived from lay literature, novels, detective stories,

plays, movies, and radio programs rather than psychiatric literature. The layman's picture of a psychiatrist, she said, was that of a "cold-blooded machine, a devil, or a god (1951:601)."

Another influential study often quoted in the literature was conducted by Cumming and Cumming (1951) and reported in their book Closed Ranks (1957). This study was a field experiment in mental health education in two small towns in Prairie County, Canada: Blackfoot, population 1500, and Deerville, population 1100; the latter town served as a control and had no educational campaign. A questionnaire surveyed attitudes in both towns; the Guttman scaling technique was used to obtain two dimensions: social distance from the mentally ill and social responsibility for the mentally ill. Response data from both Blackfoot surveys were few; only 60 percent of the adult population responded before the educational campaign, and only 50 percent afterwards. There were no data about the characteristics of the non-respondent populations. In the control community, Deerville, no effort was made to achieve complete coverage, and responses were obtained from a sample of only 100 adults.

In this sample, most respondents were not reluctant to live in the same neighborhood with former mental patients, but they did not want to room with such people or have other close association with them. In response to the Starr case descriptions, only the paranoid schizophrenic was considered mentally ill by a majority (60 percent), and only 45 percent of those considered the illness serious. Respondents who believed that the other vignettes described a mentally ill

person ranged from 36 percent in the case of the simple schizophrenic to 4 percent for the compulsive phobic and delinquent boy. Attitudes did not change as a result of the educational campaign.

Cumming and Cumming (1957) concluded that the public's attitude was one of "denial, isolation, and insulation of mental illness" (p. 119). They were of the opinion that this attitude explained the community's rejection of former mental patients and its tolerance of poor hospital conditions and patient isolation. They further hypothesized that this attitudinal social distance was necessary for the "reaffirmation of the solidarity of the social system in which the norms are not violated"(p. 127), and that the isolation of the mentally ill reduced the guilt of those whose close friend or relative had been sent to the state hospital.

Nunnally (1961) in a five-year study at the Institute of Communication Research of the University of Illinois applied a semantic differential to a nonrepresentative sample and reached conclusions similar to those of Starr and the Cummings: public attitudes were negative and the public was uninformed rather than misinformed about mental illness. Nunnally also examined the role of the mass media in forming public attitudes. In a systematic and large scale content analysis of television, radio, newspaper, and magazines during a one-week period in 1955, he found the mental patient was stereotyped as dangerous and unpredictable and that this stereotyped image was presented as much as a hundred times more frequently than the medically correct one.

Nunnally also reported that possession of accurate information about mental illness correlated positively with age and education while attitudes toward the mentally ill did not. He concluded that educated and uneducated, old and young, had negative attitudes toward mental illness. Physicians, such as general practitioners, were no exception; their attitudes were as negative as the general public's. Nunnally said that this latter finding had important implications for referrals and use of psychological services and preventive measures. Nunnally also urged that pathological behavior be explained to the public in an entirely new language which would eliminate former connotations in order to change negative attitudes to positive public attitudes. His work exerted great influence on subsequent research. Scheff (1963) cited Nunnally in stating that negative stereotypes of the mentally ill changed slowly or not at all and that the mass media helped to maintain the negative stereotypes.

Gurin, Veroff, and Feld (1960), working at the Survey Research Center of the University of Michigan, reached rather different conclusions from Yarrow, Clausen, and Robbins (1955). In this study, wives whose husbands had been hospitalized had one predominant concern: that mental illness was regarded as a stigma. The researchers reported greater public knowledge about mental health and improved public attitudes toward the mentally ill. They stated, however, that the public's emotional reactions had not yet completely caught up with its new found knowledge.

The Joint Commission on Mental Illness and Health published its final report Action for Mental Health in 1961. The report, a summary of the available data, was influenced greatly by the work of Star, Nunnally, and the Cummings (Crocetti, Spiro, & Siassi, 1974). The results of these studies have all been discussed previously. Basically, the picture was one of rejection and punitive social response to mental illness.

Ridenour (1961), however, reached quite the opposite conclusion. Her findings reported that by the late 1950's much improvement had taken place in individual attitudes toward mental illness. Generally, people showed a willingness to admit that they were ill and to seek psychiatric help, and other positive concepts of mental health had become accepted.

Freeman and Simmons (1961a, 1961b) sought to measure the amount of stigma attached to the mentally ill by interviewing a group of relatives of former mental patients. Noting that only one study (Yarrow, Clausen, and Robbins 1955) dealt with a systematic investigation of the impact of mental illness, they found that stigma is usually discussed in vague and general terms in the relevant literature. In limited previous research, stigma ordinarily had been inferred from nondirective interviews with a few informants.

Freeman and Simmons (1961b) studied a sample of 702 relatives of all the patients who had been discharged from a particular mental hospital in the first six months of 1959 and who had stayed in the community for a period longer than 30 days. Their findings revealed that the feelings of stigma "appears to be associated with the degree of

bizarre behavior on the part of the patient, the social class or identification of family members and their personality characteristics" (p. 30). Only a small proportion of the study groups felt stigmatized by having a mental patient in the home, and "stigma defined as sensitivity to the reactions of community associates, accompanied by withdrawal and concealment is characteristic of only a minority of families of mental patients" (p. 316).

Lemkau and Crocetti of the School of Public Health and Hygiene, John Hopkins University, published the results of their 1959-1960 study in 1962 and 1963. The setting was a lower socio-economic section of Baltimore that was to benefit from a planned expansion of home-care programs for the mentally ill. Its primary purpose was an attempt to predict the possible fate of such programs using trained interviewers to survey a randomly selected sample of 1,738 people; they obtained a response rate of 90 percent. Questions used in this study were similar to those of previous surveys, and three of the six Star (1955) case descriptions were included. The subjects were relatively poor and uneducated. Nevertheless, a majority of the respondents identified all three vignettes as indicative of mental illness, felt that the described persons should see a physician, and favored treating the mentally ill in the community. These responses did not support the concept of denial, rejection, and isolation of mentally ill persons.

Meyer (1964) surveyed the attitudes of the population of Easton, Maryland, in 1962. Those in his sample of 100 were also knowledgeable about mental illness and were generally accepting of the mentally ill.

Seventy-eight percent did not feel that all mental patients were dangerous, and 88 percent did not think that locked doors were the best way to handle hospital patients. Ninety-four percent knew of the existence of different forms of mental illness, and 89 percent favored home care for mental patients where medically appropriate.

In 1961, Phillips (1964) conducted a study in Bradford, Connecticut, a town of 17,000 inhabitants, where he obtained a sample of over 300 married women. In his interviews, Phillips presented his own description of a normal person and four of Star's vignettes, combined with information about the source of help that the described individual was using. Such sources included seeking no help, seeing a clergyman, consulting a physician, consulting a psychiatrist, and being in a mental hospital. The sex of the person was not important. The respondents were then asked five social-distance questions with the rejection score calculated as the mean number of rejective answers. Some of Phillips' findings were that individuals were rejected on a five-point scale in the following order: when no help was sought, 1.35; when help was sought from a clergyman, 1.57; from a physician, 1.87; from a psychiatrist, 2.56; and from a mental hospital, 3.04. In other words, the mentally ill person who sought help for emotional problems was more frequently rejected by others in the community; the cost of seeking help was rejection by others and consequently a negative self-image. He thus felt that one should balance the gain from psychiatric treatment against its cost to self-esteem.

Further analyzing his data, Phillips (1964) concluded that rejective behavior was correlated with the extent that the behavior was visibly different from role expectations. Men were rejected more strongly than women in every category of behavior deviation, and visibility rather than severity of destructive behavior of a former mental hospital patient was the major factor in rejection.

The Columbia University School of Public Health and Administrative Medicine and the New York City Community Mental Health Board attempted to assess the feelings of adult New Yorkers about their mental health services in 1963. The public's conception of mental illness and attitudes toward the mentally ill were explored in the survey (Elinson, Padilla, & Perkins, 1967). A random sample of 3,000 people was systematically selected from 1,500 housing units. Results were similar to those of the Maryland survey. Elinson, et al. (1967) reported that the idea of stigmatization and rejection was outmoded, that the public hoped for a favorable outcome from treatment of the patient, and accepted the newer policy that this should be included in regular health insurance coverage. Although a majority felt that it was not easy to recognize women who had had a serious mental illness, they also believed that little could be done for the mentally ill. Ninety percent of the sample felt that the government should spend more money on mental health services. Eighty percent of those interviewed were willing to work with a former mental hospital patient; 64 percent to hire him; 43 percent to work under him; and 69 percent to have him as their neighbor. However 52 percent would not be willing to agree

to his marrying into their family, and 57 percent would not share an apartment with him. It was also reported that one out of two adults in New York admitted to having had personal problems themselves for which they could have used help.

Edgerton and Hollister (1973) studied two counties in North Carolina to determine their mental health program needs. Surveying a random sample of 960 adults, they received a 97 percent response rate. The sample was primarily rural, poorly educated, and of low socioeconomic status with a median family income of less than $4,000. Nearly 40 percent of the respondents had incomes below the $3,000 poverty level. Only 4 percent of the respondents had graduated from college, while 51 percent had not gone beyond the ninth grade. The median age was 46 years, with 32 percent being urban and 68 percent rural. Most of the evidence supported the view that when people recognized a person was mentally ill, they tended to reject him. Oddly enough, however, the willingness of the general public to interact with former mental patients was found to be significantly greater than that of teachers. Looking for an explanation, the investigators noted that teachers in any community were in a highly exposed position, might be sensitive to the consequences of being labeled mentally ill, and as a result felt that close acceptance of former mental patients could lead to "guilt by association."

Several studies provided additional details on public attitudes. Older women have been found to be more rejective than older men, and black women more rejective than black men (Chin-Shong, 1968).

Whatley (1959) found a slightly greater acceptance of the mentally ill among his single respondents than among married ones; divorced and separated persons were more rejective than either married or single individuals. He suggested that personalities most susceptible to divorce might also be those most likely to reject the mentally ill.

Blacks have been found to have a more negative response to the mentally ill than whites in the research of Ramsey and Siepp (1948), Crawford, Rollins, and Sutherland (1960), and Whatley (1959). Although these studies did not intercorrelate ethnicity with age or sex, black women were noted as particularly rejective of the mentally ill.

As early as 1939, Davis pointed out that the better educated are more accepting of the mentally ill on humanistic and liberal grounds rather than because of any enlightened or scientific understanding of psychopathology. That educated persons show greater acceptance of former mental patients or those who have been mentally ill was reported by Ramsey and Siepp (1948), Woodward (1951), the Cummings (1957), Whatley (1959), Lemkau and Crocetti (1962), and Phillips (1964). On the other hand, Dohrenwend and Chin-Shong found that education had only a small negative correlation with rejection (1967), while Freeman and Kassebaum (1960) found little relation and Nunnally (1961) found none.

In summary, the studies have demonstrated two prevailing points of view regarding the public's attitude toward mental illness. Several researchers reported great social distance between the public

and the mentally ill, but others found much less. Some concluded that the public is unable to identify mental illness, but others found them quite able to do so. Some investigators saw the public's attitude as hard to change or even necessarily rejective while others claimed that these attitudes have changed. These discrepancies and contradictions can probably be best explained by considering the section of the country where the study was conducted, the subjects used in the sample, instruments used and methodology employed. Nevertheless, from the literature, the issue still appears to be a controversial one.

Literature on Attitudes and Attitude Change

As attitudes are of great importance in determining one's perceptions and job satisfactions, identifying the determinants of attitude change assumes great importance in the helping professions. Persons of all ages have been interested in the discovery of techniques whereby attitudes could be successfully influenced. Through the years, from Aristotle's serious treatment of the problem in his Rhetoric and Poetics to Dale Carnegie's How to Win Friends and Influence People (1937), men have found a ready and enthusiastic audience for their tips on how to be persuasive. Lay persons sometimes expect social psychologists to know all there is to know about the minds of man (Mills, 1972), but contemporary social psychologists are not under this illusion. They know that many gaps in knowledge remain and much work needs to be done before definitive statements can be made about how attitudes are changed. The first systematic and controlled experimental program in attitude change was not begun until the late 1940's when an inquiry

was conducted by Carl Hovland and his associate at Yale University (Mills, 1972).

A major justification for studying attitudes toward any group of people is to effect changes in attitudes. The present study attempts to change attitudes by using three types of attitude change treatment. Osgood, Succi, and Tannenbaum (1957) described attitudes as predispositions toward behavior. They did not account for all of the variance involved in a decision toward a particular behavior, but they did account for some variables which were one aspect of planning behavior change of particular groups.

Independent variables as possible correlates of change in measured attitudes were a) Contact, b) Information, c) Contact-plus-Information, and d) a non-treatment control group.

Contact

Anthony and Cannon (1969) found no effect on physically normal children's attitudes toward physical disability as a result of attendance at a 2-week summer camp with physically handicapped children. The findings indicated a nonsignificant tendency for children with negative attitudes to become even more negative. Similarly, Centers and Centers (1963) found that children who attended class with amputee children had significantly more rejecting attitudes toward amputee children than did a matched group of nonhandicapped children. In a study of adult attitudes, Granofsky (1966) was unable to improve the attitudes of volunteer hospital workers toward the physically

disabled by arranging eight hours of social contact between volunteers and a group of physically disabled men.

Stauch (1970) studied attitudes of normal adolescents who had social contact with EMR (educable mentally retarded) adolescents through special education subjects in school. This group was compared with another group of normal adolescents who had not had such contact. Results indicated that contact per se was not sufficient to produce more positive attitudes toward EMR pupils. Stauch suggested that such social contact might have an opposite effect: it could produce negative attitudes. The author stated that if social contact were to be successful, it would have to involve cooperative activities where retarded and non-retarded pupils worked together on some particular task.

Chennault (1967) attempted this. In this study, attempts were made to improve acceptance of unpopular children (Negro, I. Q. 50-70; C. A. 10-16) in eight classes. Both popular and unpopular children participated in organized cooperative group activities. Results, as measured by pre-post sociometrics, indicated that unpopular children participating in the experimental treatment improved significantly in peer acceptance and in their perceived peer acceptance. This was not true for unpopular children in the control conditions.

The unique effects of a contact experience with mental patients have recently been investigated (Spiegel, Keith-Spiegel, Zirgulis, & Wile, 1971). College students visited mental patients for 1-3 hours per week for a semester but received no supervision or information.

In posttesting compared with pretests, the students saw the typical mental patient as significantly more depressed and irritable, less neat and less interested in socialization. On the Opinions About Mental Illness Scale, scores changed on two of the five scales; the students became significantly less authoritarian but also less benevolent toward the mentally ill.

Cleland and Cochran (1961) attempted to assess the stress-producing aspects of institutional tours on attitudes of high school seniors. The tours were varied by having the subjects tour the institutions in different sequences of most shocking to least shocking wards. The results produced no significant attitude changes. Kimbrell and Luckey (1964) likewise used tours to produce attitude change in college students and did note positive change. One could hypothesize the difference as being due to the differences in ages of the subjects. However, the experimenter did not find anywhere in the literature that this speculation was supported by empirical evidence.

In summary, despite the limited number of experimental studies it appears that contact in and of itself does not effect significant change in attitudes toward persons with disabilities.

Information

Several studies investigated the attitude change of college students enrolled in an abnormal psychology course (Altrocchi & Eisdorfer, 1961; Costin & Kerr, 1962). The first study compared students in classes of abnormal psychology, personality development,

and industrial management. Even though abnormal psychology students increased their information about mental illness, their attitudes toward mental illness as measured by a semantic differential test did not change.

Costin and Kerr (1962) compared students in an abnormal psychology class with a comparable group of controls. They reported some changes for the abnormal psychology students on the Opinions About Mental Illness Scale, but no change in opinion about differences between mentally ill and normal persons. Furthermore, their scores on a scale of benevolence toward mental patients decreased.

Semmel and Dickson (1966) compared seniors in elementary education who had taken a course in special education with those who had not. No significant difference was found in attitudes measured by the Connotative Reaction Inventory, a scale designed to assess how comfortable a person says he would be in 10 social situations with a physically disabled person. Two studies of the combined effects of contact-plus-information have used an information only sample--typically psychology majors or introductory psychology students (Chinsky & Rappaport, 1970; Smith, 1969--as a control group. Neither study reported significant, positive changes in attitudes as a result of didactic course work in psychology.

Information about disabled people may be presented by a film or institutional tour. Staffieri and Klappersack (1960) showing a favorable film on cerebral palsy found no change on college students' attitudes as measured by a social distance scale. Cleland and

Chambers (1959) attempted to modify high school and college students' attitudes toward mentally retarded children, and their findings did reveal attitude changes "but not necessarily of a positive nature." The students became more open in praise of the institution and employers, but they tended to see mentally retarded children as "better off in the institution."

Sarbin and Mancuso (1970) recently reviewed educational programs designed by mental health professionals who attempted to influence the general public to consider mental illness with the same nonrejecting attitudes as somatic illness. Like the information studies, these concluded that mental health education campaigns have been notably unsuccessful in their objectives.

Quay, Bartlett, Wrightsman, and Catron (1961) used three methods of introducing information (lecture, discussion, booklet) to attendants in institutions for the retarded. Results indicated the lecture group to be the only group to produce positive changes in attitudes. The discussion group produced the least change. The authors interpreted the results to indicate that authoritative methods are most effective, particularly with particular subject populations used in the study. Lectures represent the most direct, authoritative approach, a booklet less direct but still authoritative. Discussion groups represent the least authoritative approach, incorporating democratic principles and free exchange of ideas. Bitter (1963) lent support to this idea. He attempted to change the attitudes of parents of trainable retarded children; he reported inconclusive results.

Begab (1969) presented evidence on the potency of social contact as opposed to information procedures in producing attitude change. Results indicated that knowledge through direct contact with mentally retarded people had greater impact on attitude change than knowledge alone. These findings lent support to the notion that the more direct the procedure, the greater the probability for producing attitude change.

In summary, it appears that information alone does not bring about attitude change. However, one might question whether the information presented may have been faulty or inadequate and whether some other kind of information would be effective in facilitating attitude change.

Contact-Plus-Information

Studies in this section examined attitudes toward three different disability groups: physically disabled, mentally ill, and mentally retarded. The type of contact-plus-information experience and the attitudinal measures varied from study to study.

Anthony (1969) studied the attitudes of counselors employed at a summer camp for handicapped children. The camping experience provided the counselors with information conveyed by the professionals on the camp staff as well as continuous contact. The findings indicated that at the beginning of the camping experience new counselors had significantly less positive attitudes than counselors who had worked at the camp previously but that by the end of the

summer the new counselors had significantly improved attitudes toward physically disabled persons.

In a cross-sectional study of the effects of rehabilitation counselor training, Anthony and Carkhuff (1970) found that advanced students, who generally had more contact and information about physical disability, had more positive attitudes toward physically disabled individuals than beginning students, whose attitudes did not differ from graduate students in a non-helping profession.

Rusalem (1967) attempted to change the attitudes of a group of high school girls toward the deaf-blind. A unique aspect of this study was that the students were preselected from a larger group to form two groups: one with the most positive attitudes and one with the least positive. In addition, the students did not volunteer but were required to participate in the research. The contact and information experience consisted of six 1-hour group sessions that involved information about deaf-blindness, instruction in the manual alphabet and the opportunity to communicate with deaf-blind individuals. Measures of attitude change were self-reports, a sentence completion test, and behavior. Measures of behavioral change included self-initiated volunteer work and reading about deaf-blindness. Results showed that students with the most positive attitudes did not change on the self-report or the sentence completion test, probably due to a ceiling effect, but that the group with the poorest attitudes improved on both attitude and behavioral measures.

Studies concerned with changing attitudes toward mental illness have used three kinds of subjects: student nurses in psychiatric training, college students concurrently working part-time in a mental hospital and enrolled in courses which provided them with an opportunity to discuss their work, and high school seniors. The college students were participants in programs which ranged from 30 hours (Chinsky & Rappaport, 1970) to 2 years (Smith, 1969) and varied in intensity from 40 hours per week (Kulik, Martin, & Scheibe, 1969; Scheibe, 1965) to several hours per week (Holzberg & Gewirtz, 1963; Keith-Spiegel & Spiegel, 1970). Using a variety of measures such as the Adjective Check List, Opinion About Mental Illness Scale, and the Custodial Mental Illness Ideology Scale, all of the above studies reported favorable effects on attitudes toward the mentally ill.

The effects of psychiatric nurse training on the attitudes of student nurses have been investigated repeatedly (Altrocchi & Eisdorfer, 1961; Hicks & Spaner, 1962; Lewis & Cleveland, 1966; Smith, 1969). Within a time span of 8-16 months, the psychiatric nursing experience provided the student nurse with extensive opportunities for contact as well as exposure to the professional literature in psychopathology. The research has shown consistently that this type of experience had positive effects on attitudes toward mental illness.

A study of attitudes toward mental retardation, while not a pre-posttest design, compared a group of student teachers and teachers

of mentally retarded children with teachers and students in general education and professions in other fields. The findings indicated that student teachers and teachers of the mentally retarded had the most positive attitudes (Efron & Efron, 1967). If one can assume that training to teach the mentally retarded involves both contact and information (and teaching the mentally retarded usually does involve both), these findings are consistent with previously reported positive effects of a contact-plus-information experience.

In summary, the attitudes of nondisabled persons toward persons with a disability seem to be influenced most positively by providing the disabled person with an experience which includes contact with disabled persons and information about the disability. Neither alone appears to have a significant and consistent impact on attitudes toward disabled persons. Without information, contact has only a limited positive effect or may even reinforce existing negative attitudes. Similarly, information without contact increases knowledge about the disability but appears only in some research to have an effect on attitudes.

Literature on the Self Concept

One of the most important characteristics of the personality is the self concept, an internal mental representation of the self that includes boundaries between, and identities with, the self and other individuals, groups, and ideologies. In his functioning as a member of society, the individual uses this both enduring and changing self concept to monitor his behavior and to determine the extent to which

each of his behavior patterns are ego syntonic, that is, consistent with his image of himself. This self concept, having been produced through social experience, represents social norms as it selects among possible behaviors that are consistent with the socially acceptable image that each individual presents to the world (LeVine, 1966).

Self, self-esteem, and self concept, though similar in connotation, are distinguished from one another. Self concept as a determinant of human behavior is not a recent theoretical formulation. In the Hindu scriptures during the first century B. C., there is evidence from the earliest recorded history of man that he sought to understand the causes of his conduct (LaBenne & Greene, 1969). This was mainly done through primitive religion, which considered man to have some inner regulatory agent which influenced his destiny and responded to a supernatural force. Today, scientific self psychology or ego psychology considers self concept as a hypothetical construct inferred from behavior.

An examination of the various definitions of self concept reveals that there is limited agreement among those using this term. Each of the self psychologists has defined the terms self and self concept according to the concepts utilized in building his theory (i.e. Mead, Freud, Lewin, Lundholm, Sherif & Cantril, Symonds, Cattell, and Murphy).

Mead (1934) refers to the self as an object of awareness and says that a person responds to himself with certain feelings and attitudes,

as others respond to him. Thus, he becomes self conscious (aware) by the way people react to him as an object. A person may have many different selves differentiated by specific sets of responses in various social settings. When home attitudes are expressed toward him, this creates a home self; similiarly formed are school attitudes and social attitudes in reference to self.

Mead's self as object of awareness is in contrast to Freud's conception of the ego (self) as a system of process. Freud gives the self (ego) a central place in his theory of personality structure. His conception of the self (ego) is as a functional agent or executive of the personality which makes rational choices and controls action in the healthy person. It determines what instincts may be satisfied as well as in what manner to satisfy them. Some of the duties of the ego (self) are: 1) to prevent the discharge of tension until the appropriate time, and 2) keep a "psychic balance" between the demands of the moral arena of the personality and the natural drives of the person (Freud, 1943).

Lewin thinks the self concept is encompassed by a life space region which determines present belief about the self. The term "life space" is a psychological concept to be distinguished from physical space. His conception of the self is as a functional process responding to interactions in his life space.

Briefly, some of the other well-known definitions and contributors to self concept theory are mentioned. Lundohlm (1940) defines the self as mainly what a person comes to think about himself. Symonds (1951)

sees the ego as a group of processes and the self as the manner in which the individual reacts to himself. Sherif and Cantril (1947) conceive of the self as a constellation of attitudes which include personal identity, values, possessions, and feelings of worth. Cattell (1950) considers the self as the principal organizing influence exerted upon man which gives stability and order to human behavior. Murphy (1947) defines self as the individual as known to the individual (LaBenne & Greene, 1969,p.6). Rogers (1951) views the self as object and as process. Allport (1937) thinks of the self as object and as process. James (1890) used ego to mean the individual's sense or meaning for himself which includes spiritual, material, and social aspects. Even though James' definition is listed last, much of the contemporary theorizing about the self concept is derived from him (LaBenne & Greene, 1969).

Specifically, Coleman (1964) defines self, self esteem, and self concept as follows: self (ego) - the integrating core of the personality which mediates between needs and reality; self esteem - feelings of personal worth; and self concept - the individual's assumptions about his identity and worth as a person (p. 670).

In summary, beginning with the Hindu scriptures, thoughtful persons have sought to understand man as a social animal and have made worthwhile and outstanding contributions to self concept theory.

Self Concept, Self-Acceptance and Acceptance of Others

Self concept has been studied from many different points of view. One phase of literature for this research deals with how the level of

self regard correlates with the degree of regard a person has for others. In 1961 Wylie published a critical survey of research in this area. In most of the studies this idea is expressed in terms of a relationship between self acceptance and acceptance of others.

Wylie reviewed the instruments which have been used for the stated purpose of inferring self concept and acceptance of others. Positive cross-sectional R-R correlations were found by Berger (1952), Mills, Bossom and Maslow (1957), Crandall and Bellig (1957), Fay (1954), Henry (1957), Omwake (1954), Sarnoff (1955), Worchel (1957), and Wylie (1961). The only researchers who obtained negative results were Zelen (1954), Zimmer (1965), and Zuckerman, Baer, and Monashhin (1965). Most of the subjects involved in these research projects were college students or young adults.

Correlations between the self concept and acceptance of others cited may be inflated through response set (Wylie, 1961; 1974). These response sets could be due to the omnibus arrangements of self-referent items and other referent items having a similar format, to the use of same items for self-rating and rating others, and/or subjects' tendencies to consistently use the scale ranges around a given location and a given width. However, Wylie stated in general terms that the evidence supported, with caution, the hypothesized association between self concept and acceptance of others. She noted that the wide use of R-R designs, in which two responses are correlated, can never lead to cause-effect inferences and, therefore, causal relationships cannot be inferred.

Berger (1952) investigated whether or not the evidence for a positive relationship between self concept and acceptance of others would be strengthened by an approach using larger groups and more varied samples than had previously been studied. Constructing scales to measure the expressed acceptance of self and the expressed acceptance of others, he found a satisfactory matched-half reliability and considerable evidence of the scale's validity. These scales were administered to several different groups (college students, prisoners, stutterers, counselees, adult YMCA class), and correlations between self concept and acceptance of others were determined. All were significantly positive with one exception. The findings supported previous evidence for a positive correlation between self concept and acceptance of others.

Observations prior to Berger's work center around contributions from Adler, Fromm, and Rogers. Adler (1924) observed that "a tendency to disparage" arose out of feelings of inferiority as an overcompensation. (p.84) Fromm (1939) proposed that a failure to love the self is accompanied by a basic hostility toward others which arises out of the suppression of the individual's spontaneity or his real self. Rogers (1954), while at the University of Chicago, produced clinical evidence of the relationship of attitude toward self and attitude to others, using data obtained from a counselee's statements and/or self reports in counseling sessions. A fellow researcher, using Rogers' methods, found definite and substantial correlation between attitudes of acceptance and respect for self and attitudes of respect for others (Sheerer, 1949).

Self Concept and Job Performance

Individuals who were described as more self-actualizing were more able to realize their true potentialities and to function in a more creative and effective manner (Maslow, 1958). The fully-functioning person made more effective utilization of his total organism in all spheres of activity (Rogers, 1951, 1961, 1969). People who were high in personality integration--perceptual, cognitive, physiological--functioned more effectively (Seeman, 1959). Individuals who had a clear, consistent, positive, and realistic self concept generally behaved in healthy, confident, constructive and effective ways. Such persons were more confident, secure, and self respecting. They did not have to always seek to prove themselves; difficult tasks, people, and situations were less threatening to them; they related to and worked with others more comfortably and effectively, and their perceptions of the world were less likely to be distorted (Fitts, 1965, 1970, 1972a).

Bass and Baron (1966) and Baron and Bass (1969) stated that the self concept interacted with motivation, learning, task performance and overall job performance. These authors, in a series of studies, investigated the role of social reinforcement in improving both the self concept and performance. Two types of reinforcement studied were praise of person and praise of performance in reinforcement schedules of 25 percent and 75 percent. With a population sample composed of 35 Black girls, aged 16 to 21, in a nurses' aid training program, the three experimental tasks, word recognition, experimental

treatment, praise of person or performance on an alternating 25 percent and 75 percent schedule, had more effect upon self concept than upon performance, the 25 percent schedule being more effective. The most effective type of reinforcement was praise of person, except on the manual dexterity task. Bass and Baron concluded that reinforcement schedules were more effective when they were congruent with subjects' social reinforcement standards.

In subsequent studies Bass and Baron (1969), used different samples of Black subjects to investigate the variables of verbal versus material reinforcers, level of self concept, and reinforcement history, peer group reinforcement, positive versus negative reward, and presence or absence of experimenter, both singly and in combination. They demonstrated that the interaction between self concept and job performance was complex and affected by many factors. From this study, Bass and Baron concluded their most provocative findings to be: 1) the possible efficacy of low levels of reinforcement, 2) the importance of matching personality with type of reinforcement, and 3) the superiority of peer reinforcement to that of a white authority figure. Other findings were that the self concept could be significantly changed by systematic reinforcement over short time intervals and that people with differing self concepts responded to different kinds of reinforcement (p. 48).

Shumaker (1969) conducted a study on the effects of work on hospitalized psychiatric patients. The subjects were divided into two groups, one composed of those with good prehospital work histories and those with poor work histories. Both groups were working in a

tomato cannery while hospitalized. The three hypotheses tested were that 1) subjects with good work histories would show more positive self concept change; 2) subjects with good work histories would receive better work evaluations at the cannery; and 3) the self concept changes would generate constructive behavior changes (obtaining and holding employment for three months). The three hypotheses were supported.

In summary, Bass and Baron (1969) and Shumaker (1969) provide illustrations of the interaction between work and self concept.

Self Concept and Social Behavior

The Tennessee Self Concept Scale Manual reported correlational data between self concept scores and a measure of authoritarian tendencies using the California F-Scale. Some investigators who have studied the relationship between self concept variables and authoritarian tendencies, attitudinal rigidity or dogmatism, employing Rokeach's (1960) Dogmatism, or D Scale were Bailey (1968), Dowdall (1967), Hands (1967), Johnson (1968), Lamb (1968), H. McFarland (1970), Queen (1969), Vacchiano and Strauss (1968), and Walton (1971). The data from these studies were neither significant nor consistent across studies.

The purpose of these investigations, using the Tennessee Self Concept Scale was to test Rokeach's (1960) formulation of open and closed belief-disbelief systems as basic dimensions of personality. Rokeach maintained that the belief system was composed of the beliefs, sets and expectancies that one accepted as true; the disbelief system comprised a series of subsystems which were rejected as false. The

belief-disbelief can be either open or closed, and the dogmatic person was viewed as "closed minded" or characterized by a closed belief system. Therefore, the nature of one's belief-disbelief system can be expressed on a continuum ranging from openmindedness to closed mindedness, and one's position on this continuum was determined by his score on the Dogmatism Scale or D Scale (Rokeach, 1960); higher scores reflected a more dogmatic or closed-minded person.

Two other correlational studies which used the Tennessee Self Concept Scale, and scores on the F-Authoritarian Personality Scale or F-Scale (Adorno, et al., 1950) were Fitts (1965) for 68 subjects and Queen (1969). Fitts found that there was a general but slight negative relationship between the Tennessee Self Concept Scale D (Distribution Score) and scores on both the D Scale and the F Scale. This suggested that people who are high in dogmatism or authoritarianism tended to be less definite or certain in their self-descriptions. Queen (1969) predicted that there would be a negative correlation between the Tennessee Self Concept Scale Total P Score and scores on the Christie-McGee revision of the F-Scale (Christie, et al., 1958). However, she found a correlation coefficient of only .08, which did not confirm her prediction of a relationship between high positive self concept and low authoritarianism.

In summary, the data from the studies discussed failed to portray any appreciable relationship between self concept and dogmatism. As stated by Fitts (1972b), if there is any strong relationship between these variables, it may well be curvilinear.

Summary

In this chapter, the relevant literature was reviewed and mention was made of the areas covered in the literature search.

Literature concerning attitude change toward disabled persons supported the thesis that attitudes can be influenced positively by providing individuals with an experience which includes contact with disabled persons and information about the disability. There were conflicting data as to whether information alone or contact alone was capable of changing attitudes. On the other hand, studies reporting the use of a contact-plus-information method had more positive results than information alone or contact alone.

The literature concerned with the self concept as related to acceptance of others and job performance, though sparse, was reviewed briefly. The clinical and research findings surveyed in the literature support the relationship between self concept and acceptance of others. Lack of clearly supported hypotheses in these areas appears to establish the need for additional empirical research.

CHAPTER III

METHODS AND PROCEDURES

The purpose of this study was to attempt to obtain a positive change in the attitudes of paraprofessionals in community mental health toward mental illness, their work, and professionals; to determine how these attitudes relate to self concept, and to measure the stability of changed attitudes. This chapter describes the methods of the study: the locale of the population sample, characteristics of the sample population, experimental design and procedure of treatment, pilot study, and methods for the statistical analysis of data.

The Sample

The population of this study is here defined and the characteristics of the subjects are discussed.

Locale of the Study

The sample selected for the research was the paraprofessional trainees in community mental health programs in two community colleges in North Carolina: Wayne Community College, Goldsboro, North Carolina; and Western Piedmont Community College, Morganton, North Carolina. These two colleges were selected from the six community colleges in North Carolina which offer associate degrees in community mental health on the following principles: the similarity of their curricula, their proximity to a psychiatric facility, and geographical area--one being

located in the far eastern part of the state, and the other in the far western part of the state. The experimenter studied and compared the curricula of all community college programs in community mental health, and concluded that it was reasonable to assume that those two schools were representative.

Directors of the programs selected for this research gave their consent to allow their trainees to engage in this study. All students were required to participate in this research as part of their training since the treatment program was built into the regular curriculum. The directors and instructors were aware of the purposes of the research but the students were not informed until the delayed posttesting period. As community mental health programs are innovative and experimental in nature, there were no obstacles to carrying through a new experimental segment in the curriculum.

Students were recruited to the mental health programs on the basis of their interests, previous job experiences, educational backgrounds, and some director judgment. A few students, however, were sent to the program by their employers as a part of an agency or institution's in-service training program.

A total of 107 subjects comprised the initial sample: 61 from Wayne Community College and 46 from Western Piedmont Community College. The final sample for this research, after attrition, consisted of 93 subjects (48 from Wayne Community College and 45 from Western Piedmont Community College). Any students who already worked or had previously worked at the psychiatric hospital were excluded; this number was larger at Wayne Community College.

Characteristics of the Sample

Demographic information on the subjects included age, sex, education, marital status, ethnic affiliation, and previous job experience. (See Table 1.)

The age range of the subjects varied widely; the great majority of each group was in the age range 18-27. The oldest was 53, while the youngest was 18. The median age for each college was as follows: Wayne Community College = 26.3 years, and Western Piedmont Community College = 24.5 years.

In education, 98 percent of the subjects at Wayne Community College had a high school diploma, and 2 percent had associate degrees. At Western Piedmont Community College, 84 percent had a high school diploma or its equivalent, and the remaining 16 percent had associate degrees in varied areas. More than half of the subjects from both schools had a previous job before entering the community mental health program.

Each subject was asked to indicate occupation, education, and income. Classifying these according to Hollingshead's Two Factor Index of Social Position, 75 percent of the sample of 93 subjects were from the lower socio-economic class; the remaining 25 percent was from the lower middle class. All subjects in the sample lived within a 50-mile radius of their respective schools.

The distribution of racial background was as follows: Wayne Community College was 50 percent Black, 50 percent White; and Western Piedmont Community College was 18 percent Black, 82 percent White.

Table 1

Characteristics of Paraprofessional Trainees

In Study Population

Characteristics	Wayne CC	Western P. CC	Total
Age			
18 - 27	31	33	64
28 - 37	10	10	20
38 - 47	5	0	5
48 - 57	2	2	4
Sex			
Male	10	20	30
Female	38	25	63
Education			
H. S. Diploma	44	38	82
Associate Degree	4	7	11
Marital Status			
Single	27	17	44
Married	14	23	37
Divorced, Widowed, Separated, Living Together	7	5	12
Ethnic Affiliation			
Black	24	8	32
White	24	37	61
Jobs			
Previous Jobs	28	32	60
No Job	17	10	27
No Response	3	3	6
Age			
Median	26.3	24.5	25.4
Range	18 - 53	18 - 48	

*Raw Data are reported in Appendix A

The overall percentage of Blacks and Whites in the sample was 34 percent Black and 66 percent White.

Experimental Design

This section will discuss an overview of the independent variables, the experimental design, assignment to groups, treatment, and detailed outline of procedures.

Overview of Independent Variable

The independent variables in this study were self concept, attitude change mechanism, and time. The first independent variable self concept is defined as "the self as perceived and known to the individual" (Newcomb, Turner, & Converse, 1965:142). This variable was divided into three levels--high positive, average, and low negative--and was measured by the Tennessee Self Concept Scale by Fitts (1974).

The treatment independent variable was an "attitude change mechanism" and was divided into four levels: 1) contact, 2) information, 3) contact-plus-information, and 4) non-treatment control group. "Contact" for this study was defined as the act of being in touch physically, cognitively, or associating with another individual in the same environment, and/or engaging in some activity together. "Information" referred to presentations of content in a structured classroom situation such as viewing, reading, limited discussion, telling, or being told something. "Contact-plus-information" described a combination of contact and information as described above. The non-treatment control group was designated as receiving information and/or participating in activities not related to mental health training and not used by the other three groups.

The third independent variable was time. This variable denotes the specific time periods when the research instruments were administered to the subjects. There were three periods: pretest, posttest, and delayed posttest.

Experimental Design

A variation of Campbell and Stanley's (1963) Pretest-Posttest Control Group Design was used. In conducting this experiment, there were three independent variables: self concept, attitude change mechanism, and time; each variable had 3, 4, and 3 levels respectively. This constituted a three-factor analysis of variance design with repeated measures on the third factor. (See Tables 2,3.) However, since the Treatment Program was administered at the two schools over different time periods (2 days versus 4 days), a fourth variable, school, was also analyzed in a preliminary study. Because there appeared to be differences in performance in the two environments, the study was conducted as replications in the two schools. Data were analyzed separately for each school.

A fourth variable, race, was likewise analyzed in a preliminary study due to the composition of the sample population at one of the schools. These data were discussed for one school whose population sample comprised a 50:50 ratio of subjects of different ethnic groups. (See Table 3.)

Table 2

Matrix Representation of Three-Factor Analysis of Variance Experimental Design

	B	C_1	C_2	C_3
A_1	1			
	2			
	3			
	4			
A_2	1			
	2			
	3			
	4			
A_3	1			
	2			
	3			
	4			

Table 3

Matrix Representation of Four-Factor Analysis of Variance Experimental Design

	B	C_1	C_2	C_3	C_1	C_2	C_3
A_1	1						
	2						
	3						
	4						
A_2	1						
	2						
	3						
	4						
A_3	1						
	2						
	3						
	4						

Assignment to Groups

The subjects in this study were randomly assigned to four treatment groups from subject pools based on the pretest scores on the Tennessee Self Concept Scale. The specific score used in the manual for differentiating patients from non-patients was described by the author as 10 score units on the Number of Deviant Signs (NDS) scale. A list of subjects' names, with their corresponding scores, was divided into thirds and placed into three pools designated high positive self concept, average self concept, and low negative self concept. One raw score of 18 was randomly assigned to the average self concept group, and two raw scores of 18 were randomly assigned to the low negative self concept group. Therefore, for this research, high positive self concept was set equal to 0-6 raw scores, average self concept was set equal to 7-18 raw scores, and low negative self concept was set equal to 18 and above raw scores. Names on folded paper, with their corresponding scores, were then systematically selected from the three pools, and randomly assigned to four treatment groups. After this randomization of subjects to four groups, the treatment levels were then listed on four pieces of paper, folded, and randomly assigned to the four groups (i.e. contact, information, contact-plus-information, and control). The experimenter listed names, scores and levels of treatment on paper and folded them, but the drawing was executed by a second party.

Treatment

The four levels of the independent variable "attitude change mechanism" (i.e. contact, information, contact-plus-information, and

control), constituted the Treatment Program. As stated previously, the four levels of this independent variable were randomly assigned to the four groups.

In order to insure "exact" replication of the Treatment Program from one college to another, the experimenter typed up all instructions to subjects and assistants and lectures given by her in detail. The experimenter also recorded the entire Treatment Program on cassette tapes except for Level I of the treatment since it was not a lecture. The individuals who assisted the experimenter performed the same duties throughout the entire Treatment Program (Assignments of all assistants are listed in Appendix B). To further minimize variations in the manipulation of the Treatment Program, the assistants and the experimenter listened to the taped version of the first administration at Western Piedmont Community College; then each person in the different areas attempted to replicate previous activities.

During the administration of the research instruments, the behavior of the individual in charge of the administration was evaluated on a form (See Appendix B). In addition, all sessions dealing with the administration of the research instruments were also recorded on cassette tapes.

To further facilitate a smooth execution of the Treatment Program, all subjects were given schedules showing where they were to be at a certain hour, the person(s) in charge at that time, and in what activities they were supposed to be engaged (See Appendix B).

In working out the details for the Treatment Program at Wayne Community College, it was found that in order for the subjects in

Group III to spend the necessary time at the psychiatric hospital, they would have to eat lunch in the cafeteria there. Therefore, the experimenter gave each subject at both schools (i.e., Wayne Community College and Western Piedmont Community College) $1.50 for lunch for two days. This was done so that payment would not become a confounding variable. The matter was explained to the subjects while they were together as one group at their respective schools.

This program was instituted in order to cause a change in attitudes of the subjects toward mental illness, their work, and professionals in community mental health. A brief summary of treatment is given, followed by a detailed description of all procedures.

Level I Contact

Subjects spent a total of 10 hours at the psychiatric hospital in proximity of the school. Before going to the hospital, they were given a list of "Do's and Don'ts" concerning their interaction with the patients. They were also given log sheets on which to record their activities and opinions (See Appendix B). The subjects were further instructed, by their immediate supervisor (one of the assistants) and the experimenter, on how to establish the relationship of a "friend," "helper," or "comrade," or in essence, someone who cares, with the patients. Additional instructions to subjects were for them not to play the role of a therapist, and not to interrogate the patients, but to let the patients take the initiative in the interaction.

All subjects were given the same dialog to use as an introduction of themselves to the patients, with minor individual variations, of course, in order that their words would seem natural and not stilted.

This dialog read as follows:

> I am _____(name)_____, and I will be in __(name of therapy)__ for _____ days. During this time, I would like to assist you in doing whatever you do; whether it is engaging in exercises, playing a game, making something, or taking a walk. This is a part of my training as a paraprofessional trainee.

Subjects were also indirectly supervised by hospital personnel, but supervision was not so direct that it encroached on the natural interaction of trainee and patient. However, the welfare of the patients was of primary importance to all concerned parties at all times.

The Director of Clinical Services and Activities permitted the subjects to interact with the patients in all of the activity therapies (i.e., recreational, occupational, music, industrial, and sheltered workshop). The activities in which the subjects and patients participated were varied and included modern dance, isometric exercises, singing activities, role playing, puppet theater, ceramics, leathercraft, ping pong, walks, shuffleboard, bus rides, bingo, table games, billiards, and bowling. Many subjects worked with several patients during their 5 or 10 hour periods.

Level II Information

Subjects spent 10 hours in a structured mini-workshop dealing with information about mental illness, their work and roles as paraprofessionals, and their relationship with professionals. The mini-workshop consisted of two one-hour tapes by a counselor and a psychologist dealing with the topic "Positive Approach to Psychiatric Patients (See Appendix E), three films entitled "Who is Normal," "RX Attitudes," and

"Positive Approach to Psychiatric Patients," and a booklet entitled What Everyone Should Know About Mental Health (See Appendix E). Subjects were asked to write three one-page paragraphs on the subject "Why I Should Have a Positive Attitude Toward Mentally Ill Patients, My Work, and Professionals," and a summary of the mini-workshop (See Appendix B).

Level III Contact-Plus-Information

Subjects in this group spent 5 hours at the psychiatric hospital near the college and 5 hours in the mini-workshop dealing with information about mental illness, their work and professionals in community mental health. They went with the Level I group for the first 5 hours, then returned to the campus and went in the room with the Level II group (See Appendix B). The individual time spent in Level I and Level II activities was cut in half.

Level IV Control

Subjects in this group were exposed to materials dealing with communication styles, an introduction to transactional analysis, and an introduction to reality therapy (See Appendix E). The methodology employed was lecture, discussion, tapes, physical exercises, and written exercises.

Detailed Outline of Procedures

Phase I: Initial Assessment of Attitudes and Self Concept

Before the pretesting of subjects at both colleges, the directors of the two community mental health programs and the experimenter had agreed on the following introduction:

> Students, Mrs. _____ is one of the guest lecturers for our program this year. She is going to engage in several activities with you for a period of _____ days during the first semester. I want you to listen carefully and do as she asks you, because this is a part of your required curriculum. She has three assistants whom she will introduce to you. Mrs. _____ _____.

The original plans were to administer the Tennessee Self Concept Scale first, then the Opinions About Mental Illness Scale, and last the Attitude Toward Work and Professionals Scale. However, it was decided after administration in the Pilot Study that another arrangement would be more appropriate and would facilitate a smoother and more efficient administration. The arrangement decided upon was to administer the Attitude Toward Work and Professionals Scale, the Opinions About Mental Illness Scale, and then the Tennessee Self Concept Scale. This order was decided upon due to the amount of time it took the subjects in the Pilot Study to complete the research instruments. The subjects had a tendency to tire more quickly when the TSCS was administered first. Consequently, students were not as alert for the administration of the other two instruments.

Following the introduction of the experimenter by the directors of the program, the researcher then introduced her three assistants (one in psychology, one in special education, and the third in counseling). The researcher then asked the subjects' cooperation in participating in a survey of attitudes and opinions about mental illness, their work and about professionals as part of the process of internal evaluation inherent in programs of this nature. Confidentiality of results was assured. Assistants then distributed the Attitude Toward Work and

Professional Scale and pencils. The following instructions were read:

> This instrument measures your attitudes toward work and professionals in community mental health. Please read the directions and begin. If there are any questions, please raise your hand.

In approximately 15 minutes, all subjects had completed this form, which was then collected, and the Opinions About Mental Illness Scale was distributed. The following instructions were read:

> The statements on this instrument are opinions or ideas about mental illness and mental patients. By mental illness, we mean the kinds of illness which bring patients to mental hospitals, and by mental patients we mean mental hospital patients. There are differences of opinions about this subject. In other words, many people agree with each of the statements in this booklet while many people disagree with each of the statements. We would like to know what YOU think about these statements. Each of them is followed by six choices: strongly agree_____,agree_____,not sure but probably agree_____,not sure but probably disagree_____, disagree_____,strongly disagree_____
> Please check (✓) in the space provided that choice which comes closest to saying how you feel about each statement. You can be sure that many people, including doctors, will agree with your choice. There are no right and wrong answers, we are interested only in your opinion. It is very important that you answer every item.

Subjects were allowed 20 minutes to complete this instrument; most of them finished within approximately 15 minutes, and all of them within 18 minutes. The scale was then collected, and the Tennessee Self Concept Scale was distributed. The subjects were informed that this was the last instrument that they were going to take at that time. They were informed that it would take approximately 25 minutes for everyone to finish. The following instructions were read:

On the top line of the separate answer sheet, fill in your name and the other information except for the time information in the last three boxes. You will fill these boxes in later. Write only on the answer sheet. Do not put any marks in this booklet (booklet was held up by the experimenter). The statements in this booklet are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself to yourself. Do not omit any item! Read each statement carefully, then select one of the five responses listed below. On your answer sheet, put a circle around the response (demonstrated on chalkboard) you choose. If you want to change an answer after you have circled it, do not erase it but put an X mark through the response and then circle the response you want. When you are ready to start, find the box on your answer sheet marked time started and record the time. When you are finished, record the time finished in the box on your answer sheet marked time finished. As you start, be sure that your answer sheet and this booklet are lined up evenly so that the item numbers match each other (demonstrated to group on chalkboard). Remember, put a circle around the response number you have chosen for each statement.

RESPONSES:

Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
1	2	3	4	5

You will find these response numbers repeated at the bottom of the page to help you remember them.

When the subjects had completed this instrument, booklets, answer sheets and pencils were collected. Most of them completed the test within 20 minutes; the mean time stated in the manual is 13 minutes. Subjects were thanked for their patience and cooperation, and they were informed that some of these same instruments would be administered at a later date as a continuation of the internal evaluation process which is necessary to measure the effectiveness of programs in community mental health.

Phase II: Treatment Period

During the second general meeting with the group, names of all members of the group were called, and they were assigned to one of the four treatment groups. The randomization of subjects and the randomization of treatment for the different groups had already been completed prior to this time. The names of the subjects in each group were called a second time so that each person would definitely know to which group he belonged. Schedules for the respective groups and other necessary information were given to the subjects (See Appendix B). Each assistant and the experimenter took his group to a different room.

A brief description of what transpired in the four groups follows:

Level I Contact. Subjects in this group were told that they would spend 10 actual contact hours at the psychiatric hospital in the area with which they all were familiar for one reason or another. They would be allowed to interact with the patients and staff and assist the patients in any acceptable way possible. This interaction could be in the form of helping the patient make some item in occupational therapy or industrial therapy; teaching the patient some game or playing a game with him which he already knew in recreation therapy; dancing or singing with the patient in music therapy; or taking a walk with the patient in the sheltered workshop.

Subjects were informed of the role they would play as far as the patients were concerned and that they were not to interrogate the patients to any great extent. Subjects were also told that they would be given credit for these hours as part of their regular practicum experience.

Level II Information. Subjects in this group were informed that they would spend 10 hours in a structured mini-workshop dealing with information relative to mental illness, their work, and their roles as paraprofessionals. Their potential working relationship with professionals would also be discussed.

Subjects were further informed that they would listen to taped and live lectures with very little discussion. They would also view three short films on mental patients and be requested to perform a few verbal and written exercises.

Level III Contact-plus-Information. Subjects in this group were asked to spend 5 contact hours at the psychiatric hospital in the area and they were given the same information as the subjects in Level I. However, they were also informed that after their hospital stay, they were to return to the campus and meet with the Level II group for five hours. These subjects were told that they would view two short films on mental patients, listen to one taped lecture on the same subject, and one live lecture on professionals and paraprofessionals. They would also be expected to write three paragraphs on why they should have a positive attitude toward mental patients, their work, and professionals, in addition to writing a summary of all the activities in which they had engaged during Phase II.

Level IV Control. These subjects were given an overview of how they would spend their 10 hours. This included information on communication styles, transactional analysis, and reality therapy. They were told of the verbal and written exercises that they would be expected to perform, and that at some later date, they too would be exposed to the

same or similar activities of persons in Levels I, II, and III.

After the 10-hour period was completed for all groups, they were asked to assemble in one room for evaluative activities. When they assembled, all subjects appeared to be enthusiastic as to what they had experienced in their respective groups. The Attitude Toward Work and Professionals Scale and the Opinions About Mental Illness Scale were readministered at this time.

The subjects were thanked for their cooperation and informed that the experimenter and assistants would meet with them again after a period of 8 weeks. They were also told that the practicum experience and the mini-workshop were completed, and they were to return to their previous schedules immediately after the pretesting period.

Phase III: Delayed Time Period

Eight weeks later, all subjects at each college were regrouped into a single unit. They were informed by the experimenter of the progress that the experimenter had been told they had made in the experimenter's absence. Questions were asked by some subjects as to how long the experimenter was going to stay this time and if all subjects would get a chance to see the films, listen to the tapes, or go to the psychiatric hospital. The subjects were informed that the experimenter would investigate if some possible arrangements could be made. The experimenter did give the directors of each program the titles and addresses of the films.

Subjects were sincerely thanked for their cooperation relative to this part of the program. Then the necessary materials were again distributed at the appropriate times (i.e., pencils and research instruments)

and subjects were requested to fill in the necessary information. All instruments were distributed and administered in the same sequence as they were in the pre-and posttesting sessions. No further explanations were given. Subjects were asked to raise their hands if they had questions.

After the collection of all research instruments and pencils, the subjects were again thanked for their cooperation and given a debriefing. This included a general statement relative to the internal evaluation of paraprofessional programs in community mental health, the important role that they were now playing, and the expected role that they would play in this much necessary "revolution" by participating in the program and cooperating with this research. Their directors and the experimenter promised them that they would receive information relative to their participation as a group. However, all personal, individual identification of their participation would be held in the strictest confidence. "Best wishes," "Good Luck," and pleasant "Good Byes" were bestowed on the experimenter and the assistants. Some requests were made by subjects for assistance in entering the community mental health program at the North Carolina Agricultural and Technical State University, after completing their associate degree.

The last two sentences were added in order to try to portray some image of the debriefing effect, since some debriefings are accompanied by hostility and resentment if subjects are not informed, in advance, as to the purposes of an experiment.

The Research Instrument

The Tennessee Self Concept Scale

(See Appendix C) This scale was devised by William H. Fitts in 1964. It consists of 100 self description items, of which 90 assess the self concept and 10 assess self criticism (the self-criticism items are all MMPI Lie Scale items). For each item, the respondent chooses one of five responses labeled from "completely false" to "completely true." There is a Counseling Form and a Clinical and Research Form. The Clinical and Research Form was used in this study. Thirty scores were derived and reported in the Profile Sheet.

Items for the scale were written according to a two-dimensional scheme dealing with internal and external referents. This two-dimensional scheme involved the following aspects of the self: Identity, Self-Satisfaction, Behavior, Physical Self, Moral-Ethical Self, Personal Self, Family Self, and Social Self. From these subscores, major additional scores were derived: Total Positive Score, reflecting the overall level of self-esteem; Variability Scores, reflecting the amount of consistency from one area of self perception to another; Distribution Score, a measure of extremity and response style. According to Buros (1972) "the Clinical and Research Form yields scores for a True-False Ratio, a measure of response items; Empirical Scale for group discrimination of various sorts; and Number of Deviant Signs Score, a count of the number of deviant features on all other scores. The various content areas are well conceived, and the scale yields a vast amount of information from only 100 test items" (p. 152).

In choosing the Tennessee Self Concept Scale, the following test data were taken into account: the remarkably high correlations with other measures of personality functioning, such as the Taylor Anxiety Scale which correlates -.70 with Total Positive, the Cornell Medical Index and an unpublished Inventory of Feelings which correlated .50 to .70 respectively. Correlations in the .50's and .60's are very frequent with various MMPI Scales. Since the Tennessee Self Concept Scale seems to overlap sufficiently with well known measures, it seems safe to consider it a possible alternative for these measures in various applied situations. The scale was normed on a sample of 626 persons of varying age, sex, race, and socioeconomic status. Even though the sample does not reflect the distribution of these variables in the population, the experimenter believes that it will suffice for this study. Retest reliability, while varying for different scales, is in the high .80's; thus it appears to be sufficiently large to warrant confidence in individual difference measurement (Buros, 1972).

Many researchers have used this instrument in conducting studies related to the self concept since it was devised in 1964 (Buros, 1972).

Measurement of Dependent Variables and Test Analysis

The research instruments that were used to measure the subjects' attitudes toward mental illness, their work, and professionals in community mental health were the Opinions About Mental Illness Scale, by Cohen and Struening (1962) and the Attitude Toward Work and Professionals Scale which was specifically constructed for this research from scales Douthit used (1971) and Sampson (1973). Details

pertaining to each scale are discussed below.

Opinions About Mental Illness Scale. (See Appendix C-1) The meth

base from which Cohen and Struening's (1962) investigation proceeded in the construction of this scale was that opinions about mental illness are potentially multidimensional.

Cohen and Struening conceived of attitudes as inferred variables which carry an affective or at least an adient-avoident valence. "Operationally, then our responses reflect opinions, and the factors derived therefrom may represent attitudes" (Cohen & Struening, 1962, p. 349).

A collection of 70 Likert-type items describing attitudes toward the mentally ill was administered to the employees in two large, geographically separated Veterans Administration Neuropsychiatric hospitals (number of subjects at each hospital--541 and 653). As a result of the analysis, five opinion attitude dimensions were identified. The five factors have positive poles defined as follows:

> A - Authoritarianism: Defined in terms of content concerning attitudes toward the mentally ill, this is virtually identical with the California F dimension (Adorno, et al., 1950). It includes authoritarianism submission, and intra-introception and reveals a view of the mentally ill as an inferior class requiring coercive handling.
>
> B - Benevolence: A kindly paternalism whose origins lie in religion and humanism rather than science or the sophistication of professionalism.
>
> C - Mental Hygiene Ideology: A positive orientation which embodies the belief of the present day mental health worker and the tenets of the mental hygiene movement. Its core concepts are partially summarized by the item "mental illness is an illness like any other."
>
> D - Social Restrictiveness: The general idea here is that the mental patient constitutes a threat to society,

> particularly to the family unit and must therefore be restricted in his functioning during hospitalization and afterwards.
>
> E - Interpersonal Etiology: Whereas the other four factors are attitudinal, E is a circumscribed cognitive factor which reflects the belief that mental illness arises from interpersonal experience, especially deprivation of parental love during childhood.

There is some tendency for A and D to form one cluster, B and C to form another, and for the two clusters to be negatively related. E is negligibly related to the other scales (Cohen & Struening, 1962, 1963).

The Opinions About Mental Illness Scale has been used in several studies dealing with attitudes toward mental illness (Appleby, Lawrence, Ellis, Rogers, & Zimmerman, 1960; Chinsky & Rappaport, 1970; Clark & Binks, 1966; Jaffe, 1967; Lieberman, 1970; Nudelman, 1965; Struening & Cohen, 1963).

Reliability and validity data were not mentioned by any source except those of Cohen and Struening during their construction of the scale. They stated--

> The reliability coefficients given are of the internal consistency type, equivalent to those obtained by the generalized Kuder-Richardson formula 20. . ., and are to be understood as giving an estimate of the correlation one would obtain from composites of the same number of items drawn randomly from the same domain (Tryon, 1957).
>
> The factor validity coefficients were computed by means of Thompson's (1951, pp. 197-199) pooling square. The resulting value represents the correlation coefficient between the sum of a set of item scores and the factor they share in common. The validity coefficients are also quite satisfactory for the purposes of group comparisons (Cohen & Struening, 1961

Scores on the five dimensions described on the previous page were used in the assessment and analysis of differences in reference to the three independent variables used in this study (i.e., self concept, attitude change mechanism, and time).

Attitudes Toward Work and Professionals Scale. (See Appendix C-2). A suitable instrument could not be found to measure attitudes toward work and professionals, therefore a special scale was developed for this study.

Section One contained 21 items taken from the Job Descriptive Index developed by Smith, Kendall, and Hulin (1969). Items used were from the subscales of a) Work on Present Job, and b) Opportunities for Promotion.

The Job Descriptive Index was developed by Smith, Kendall, and Hulin (1969) and consisted of 72 items designed to elicit job satisfaction. It is composed of a list of adjectives or short phrases for subscales. The respondent is instructed to indicate through a "yes," "no," or "uncertain" whether each word or phrase applies with respect to his job in question. "Yes" answers to a positive item are scored 3; "no" answers to a negative item are scored 3; "uncertain" answers to any item are scored 1; "yes" answers to a negative item are scored 1; "no" answers to a positive item are scored 1.

The Job Descriptive Index requires a low verbal level for persons taking it. The respondent is not required to understand complicated or vague abstractions. The educational level in the plant where it was developed averaged fourth grade. All participants who read English were able to respond. The responses are job referent rather than

self-referent in that the person is describing his job, but the information he provides may be used to infer his satisfaction. Studies using the Job Descriptive Index demonstrated that a person's perception of his work was highly colored by his satisfaction with it. Some of the descriptive words or phrases are evaluative (i.e., pleasant, frustrating), while others are objective (i.e., on your feet, dead-end job). The descriptive format was used because the authors felt that responses about specific aspects of a job are more measurable than responses describing internal states of feelings.

The Job Descriptive Index items are balanced in a number of positive and negative items to control for responses and acquiesence sets. Responses of 952 people in seven different organizations were used in developing the instrument. The reliability of the Job Descriptive Index was reported at .80 (split-half). The instrument has been found to correlate -.27 between satisfaction and turnover on the job. Therefore, validity would seem adequate (Smith et al., 1965).

Section Two of the Attitudes Toward Work and Professionals Scale developed for this research contained 23 items to measure attitude toward professionals. These items were modified from two studies, one by Douthit (1971) in a doctoral study dealing with "The Relationship Between Rehabilitation Counselor Attitudes Toward Self and Profession and Attitudes Toward Paraprofessionals," and one by the experimenter (Sampson, 1973) concerned with the utilization of paraprofessionals in community mental health.

The Attitude Toward Paraprofessional Scale, by Douthit (1971) collected one hundred and fifty statements which expressed subjective and objective views that seemed favorable or unfavorable toward

paraprofessionals. According to guidelines, Douthit discarded statements which were factual, could be interpreted in more than one way, and those which referred to the past rather than the present. He also excluded words such as all, always, or none. After editing, Douthit submitted his statements to a specialist in research design and attitude test construction, and to four experienced professionals in vocational rehabilitation for further evaluation. Their agreement was 100% on 34 statements; therefore, Douthit retained only those items. His final scale contained only 25 Likert type items; the others were deleted by item analysis. Reliability for the scale was established by a test of internal consistency and by the test-retest method.

The second half of Section Two was taken from a questionnaire formulated by this researcher for use at Umstead Hospital, Alcoholic Rehabilitation Center, and Murdoch Center at Butner, North Carolina (Sampson, 1973). Questions phrased by the experimenter concerned supervisors and professionals' attitudes toward the utilization of paraprofessionals in community mental health.

As the Douthit (1971) scale had measured the views of professionals toward paraprofessionals, and this research was studying instead the attitudes of paraprofessionals toward professionals, all items were revised to reflect this reversed point of reference; that is, to assess attitudes <u>toward</u> professionals.

<u>Section Three</u> was composed of demographic information necessary for this research. All the sections of the <u>Attitude Toward Work and Professionals Scale</u> were administered in the pilot study. From statements and questions of trainees taking this form, a further refinement

of items was made. The revised scale was then submitted to two psychologists and one counselor working with paraprofessionals in community mental health. After their evaluation, a third form of the scale was constructed with only those items retained on which psychologists and counselors were in complete agreement. The statements were then prepared as a Likert-type scale, with three response categories.

The highest possible score on Section One--which measures attitudes toward work--is 63 points; the highest possible score on Section Two--which measures attitudes toward professionals--is 69. The lowest possible score on Section One or Section Two is zero (0). The scoring procedure for the entire instrument is similar to the one constructed by Smith et al. (1969) for their Job Descriptive Index.

Copyright permission, advice on scoring the entire instrument (i.e., the Attitude Toward Work and Professionals Scale), and suggestions for the analysis of data obtained from it were given by the senior author, Patricia C. Smith of Bowling Green State University, Bowling Green, Ohio. The final form as used in this research appears in Appendix C-2.

Pilot Study: The Effects of a Practicum Experience on Paraprofessional Trainees

The aims of this pilot study were to develop and modify a research instrument for assessing the attitudes of paraprofessional trainees toward mental illness, their work, and professionals in community mental health, to refine the techniques and procedures for the administration of all of the research instruments, and to construct schedules and forms

to be used in the main study. Methods for quantitatively and qualitatively recording the contact experiences of the paraprofessional trainees were developed.

As mentioned in Chapter I of this investigation, due to the lack of systematic research and ambiguity of findings on paraprofessionals' attitudes toward mental illness, their work in community mental health, and toward professionals, this study was undertaken. Possible changes in the self concept were also investigated in order to further check the validity of other research using the contact and contact-plus-information method for changing attitudes and other aspects of behavior.

Method

Subjects. The sample for this pilot study consisted of 29 first- and second-year students who were enrolled in the community mental health program at North Carolina Agricultural and Technical State University in Greensboro, North Carolina[1] (see Table 3).

The background of these subjects was varied. Racially, all of the subjects were Black. In reference to sex, there were 7 males and 20 females. Subjects ranged in age from 18 to 50 years, the median age being 27.1 years. Eight of the subjects had associate degrees in other areas than community mental health, or at least 2 years of college work in a four-year institution; the remainder had a high school

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[1]Program funded by the National Institute of Mental Health, Rockville, Maryland. Grant #5 T21MH 128810 - 02 EXY for 1972-1977. Hattye H. Liston, Director.

Table 4

Demographic Characteristics of Pilot Study Population Sample*

Characteristics	Number
Age	
18 - 27	19
28 - 37	4
38 - 47	2
48 - 57	2
Sex	
Male	8
Female	19
Education	
H. S. Diploma	19
Associate Degree	8
Marital Status	
Single	8
Married	13
Divorced, Widowed, Living Together	6
Ethnic Affiliation	
Black	27
White	0
Jobs	
Previous Jobs	15
No Job	7
No Response	5
Age	
Median	27.1
Range	18 - 50

*Additional Raw Data are reported in Appendix A

diploma or its equivalent. Additional demographic data include: 13 were married, 8 were single, and 6 were separated or divorced; in work experience 22 had had previous jobs such as work in drug rehabilitation, industry, nursing homes, and the armed services.

The final sample for this pilot study numbered 27; two subjects were excluded due to their not completing the necessary research instruments after ending their practicum.

Research Instruments. The instruments used to measure the self concept, attitudes toward mental illness, work in community mental health, and professionals in the area were the Tennessee Self Concept Scale (TSCS), the Opinions About Mental Illness scale (OMI), and the Attitude Toward Work and Professionals Scale (ATWPS). These scales were administered in the order in which they are listed above.

Procedure. For the pretest condition, the experimenter explained to the subjects that some phases of internal evaluation were being carried out for the community mental health program. The researcher then asked for their cooperation in participating in this evaluation. The subjects were not informed that their forthcoming practicum experience at the Butner Complex was in any way related to their being administered the research instruments previously described. However, the experimenter, who was also the liaison person between the Butner Complex and North Carolina A. and T. State University, did mention to the subjects, after the practicum experience of 100 hours, the same instruments should have been administered to them again in order to ascertain further assurance that they had expressed their true opinions and attitudes in reference

to mental illness, their work, and professionals in community mental health. The experimenter stated that the subjects should have taken the test instruments at an earlier date after the first administration, but they had been busy with their practicum. Confidentiality of results was assured.

The research instruments were administered in the same order for the pretest and posttest: (a) Opinions About Mental Illness Scale, b) the Tennessee Self Concept Scale, and (c) the Attitude Toward Work and Professionals Scale. The same test room and the same experimenter were used for all conditions.

During the practicum experience at the Butner Complex, the subjects were assigned principally to the recreational and occupation therapy areas. They interacted with the patients and staff performing many of the same duties as the regular staff members (camping, hiking, playing games--billiards, bowling, bingo, dancing, making different items such as mats for hot dishes, ash trays, coasters, octopii out of yarn, framing pictures, and making billfolds out of leather). This practicum experience lasted for a total of 100 hours during 4 weeks. All subjects were required to keep daily logs of their experiences.

Results and Discussion

A two-way analysis of variance was used to determine whether the practicum experience of 100 clock hours was significantly related to the subjects' attitudes.

The data from the pilot study were analyzed in two different ways. The first analysis used the self concept and practicum experience as independent variables; and attitudes toward mental illness, work, and

professionals. The findings from the data revealed that neither the self concept nor the practicum experience was related to the subjects' attitudes toward mental illness and professionals, but the practicum experience did influence the subjects' attitudes toward work (.05 level of significance). The subjects' attitudes toward their work improved considerably after their practicum experience of 100 clock hours.

In Analysis II where self concept was used as a dependent variable, the null hypothesis was rejected and the alternative hypothesis was accepted at the .001 level of significance. The self concept of the subjects did change in a positive direction as a result of the practicum experience.

Summary and Conclusions

From an analysis of the data, it appeared that the practicum experience at the Butner Complex was a very important part of the paraprofessional trainees' curriculum in the school where this research was carried out; more positive attitudes toward their work resulted, and there was a very favorable change in the self concept from the practicum experience at the Butner Complex.

The findings from this pilot study were in agreement with other investigations in this area (Altrocchi & Eisdorfer, 1961; Bovard, 1958; Holzberg & Gewirtz, 1963; Minneapolis New Careers, 1969).

Measures for Controlling Extraneous Variables

Two samples of subjects from different colleges were used in this research. It was not possible for the experimenter to administer the Treatment Program to all of the subjects at one time; therefore, extra

precautions had to be instituted in order to control for extraneous variables. A brief discussion is given of the methods employed to insure an "exact" replication of the Treatment Program at each college.

All instructions were detailed and typed for the benefit of the assistants, auxiliary personnel, students, and the experimenter. The lectures given were presented on tape except the one given by the experimenter. However, this lecture was taped during the first presentation in order to insure "exact" replication at the second college.

One way of determining whether behavioral measures are reliable is through simultaneous recording by independent observers. There must be close agreement between the two, demonstrating that the behavior under observation is being measured similarly (Sulzer & Mayer, 1972). Four staff members at each school and psychiatric hospital cooperated in completing a checklist in reference to the behavior of the person in charge of each level of the Treatment Program, the subjects' behavior, and the physical environment during the testing periods and the administration of the Treatment Program (See Appendix B). These staff members were rotated from group to group so that there would always be two observers rating each level of the Treatment Program at one time. The staff members were informed of the experimenter's meaning of the terms "good," "average" and "poor" before the actual evaluative situation; and they were given a typed meaning of the terms while the evaluation was in progress. Each evaluator was seated on opposite sides of the room during the evaluation process with all groups. Even though they had been informed jointly about the scale, by the experimenter, neither person knew the score of the other. All evaluators

had been informed previously of the difficulty of administering the Treatment Program within the exact number of days at each college (2 days versus 4 days); therefore this factor was not counted in the evaluation.

The highest possible score on the evaluation checklist was 63; the lowest possible score was zero. The reliability score is calculated by comparing how well two or more independent observers agree among themselves and is reported in percentages (Sulzer and Mayer, 1972). These scores were derived by the following formula:

$$\text{Score} = \frac{\text{Number of Agreements}}{\text{Number of Disagreements \& Number of Agreements}}$$

Another measure taken was that of the assistants performing the same duties at both Wayne Community College and Western Piedmont Community College. All of the previously mentioned measures were instituted for increasing the validity of the Treatment Program during this study.

Method For Statistical Analysis of Data

An analysis of variance with three factors was performed with repeated measures on the third factor. The following dependent variables were analyzed: attitude toward mental illness, attitude toward work, and attitude toward professionals.

A preliminary analysis was done to examine school differences since the "exact" Treatment Program was distributed over two different time periods when it was administered at the different colleges; that is, Wayne Community College (2 days) and Western Piedmont Community

College (4 days). Preliminary analysis was made in order to detect if there were any interactions or differences due to schools and race. Since there were differences, it was decided to analyze the data separately for each school, and analyze it by race for one school which had an equal number of subjects from two ethnic groups.

The analysis of variance was selected as the main statistical procedure for this study because of its efficiency in testing the significance of several factors in one design. However, where a significant Omnibus F was found, it was necessary to compare the means of several groups with the Duncan Multiple Range Test. For purposes of this study, the probability level needed to reject the null hypotheses was set at .05.

CHAPTER IV

FINDINGS AND ANALYSIS OF DATA

The analysis of data is divided into three major sections: (1) control of extraneous variables, (2) presentation of results from Wayne Community College and Western Piedmont Community College, (3) presentation of results from Wayne Community College using Race as a fourth variable. Tables of data supporting the findings will be presented both within Chapter IV and in Appendix D.

Control of Extraneous Variables

Extra precautions were instituted to control for extraneous variables since two samples of subjects from different colleges were used in this research. As previously mentioned, all instructions were typed in detail and all lectures were taped either before or during the administration of the Treatment Program. Assistants performed the same duties at both Wayne Community College and Western Piedmont Community College when the treatment was administered to the subjects.

In addition to this, the reliability coefficient was calculated using the formula by Sulzer and Mayer (1972, p. 269) for the scores on the checklist used to record the behavior of the person in charge of each level of the Treatment Program, the subjects' behavior, and the physical environment during each phase of the research study.

Four reliability scores were obtained for each assistant and the experimenter at Western Piedmont Community College, and two reliability scores were obtained for each assistant and experimenter at Wayne

Community College. These scores were then added together at each school in order to arrive at one score per school for each assistant and the experimenter. The results were as follows:

Assistant	Western Piedmont Community College	Wayne Community College
	%	%
I	91	93
II	88	89
III	86	88
Experimenter	92	93

The above percentage scores for each assistant and the experimenter indicate how well or reliable their procedures were for the administration of the Treatment Program.

Presentation of Data From Wayne Community College and Western Piedmont Community College

Six different computer runs of the collected data were made using the computer research center at North Carolina Agricultural and Technical State University and the Research Triangle. After the early analyses of data, it was decided to separate the findings at Wayne Community College and Western Piedmont Community College and to report each of these. A decision was made also to report comparison findings for Blacks and Whites at Wayne Community College.

The analysis of data examined the findings in relation to four hypotheses for the five dimensions on the Opinions About Mental Illness Scale: A. Authoritarianism, B. Benevolence, C. Mental Hygiene Ideology, D. Social Restrictiveness, E. Interpersonal Etiology; and four hypotheses each in relation to Attitude Toward Work and Professionals Scale. A comparison was made between the two schools.

Since Factors A and D on the Opinions About Mental Illness scale cluster, these data are reported in succession. The same clustering occurs with Factors B and C, so they are also reported successively. The Factor E data are presented separately as it is a cognitive more than an attitudinal factor. The hypotheses will be stated for the first of the five factors on mental illness; thereafter reference will be made to each of the hypotheses by number. The remaining eight hypotheses will be restated for attitude toward work and attitude toward professionals. The hypotheses will not be restated when the analysis is made for the four factors of Self Concept, Treatment Program, Time and Race. Significance for main effects and interactions other than those related to the hypotheses will be discussed also.

Attitude Toward Mental Illness

Factor A. Authoritarianism

The results of the analysis of variance on the dependent variable, factor of Authoritarianism, are reported in Tables 5 and 6 for Wayne Community College and Western Piedmont Community College. High scores are reflective of more authoritarian attitudes.

Hypothesis 1. (Self Concept): There will be no significant differences in attitudes toward mental illness between subjects classified as High Positive Self Concept, Average Self Concept, and Low Negative Self Concept.

The null hypothesis for the main effect of self concept on authoritarianism was retained for both Wayne Community College and Western Piedmont Community College. In other words, the Self Concept of the subjects was not related to their attitudes toward mental illness on

Table 5

Analysis of Variance of the OMI[a] Factor A (Authoritarianism) Scores for Wayne Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	73.51	< 1
Treatment Program (B)	3	21.95	< 1
A x B	6	153.39	1.23
Subjects within Groups	36	124.75	
Within Subjects			
Time (C)	2	40.02	3.58*
A x C	4	6.60	< 1
B x C	6	13.15	1.18
A x B x C	12	17.45	1.56
C x Subjects within Groups	70	11.19	

[a]Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

Table 6

Analysis of Variance of the OMI[a] Factor A (Authoritarianism) Scores for Western Piedmont Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	169.90	< 1
Treatment Program (B)	3	58.95	< 1
A x B	6	72.91	1.05
Subjects within Groups	33	188.01	
Within Subjects			
Time (C)	2	6.53	< 1
A x C	4	19.35	1.48
B x C	6	16.35	1.25
A x B x C	12	17.44	1.33
C x Subjects within Groups	66	13.10	

[a]Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

the authoritarian dimension.

Hypothesis 2. (Treatment Program): There will be no significant differences in attitudes toward mental illness between subjects exposed to the four levels of treatment (attitude change mechanism): contact, information, contact-plus-information, and control.

The null hypothesis for the main effect of treatment on the Treatment Program was retained at both Wayne Community College and Western Piedmont Community College. The four levels of treatment (e.g. contact, information, contact-plus-information, and control) were not effective in changing the subjects' attitudes in reference to authoritarianism.

Hypothesis 3. (Self Concept and Treatment Program): There will be no significant differences in attitudes toward mental illness between subjects exposed to the four levels of treatment (attitude change mechanism) and Self Concept of the subjects. The null hypothesis was retained for both Wayne Community College and Western Piedmont Community College. In essence, this meant that there was no significant interaction of the different self concept groups and the Treatment Program in reference to the subjects' attitudes on the authoritarianism dimension.

Hypothesis 4. Self Concept, Treatment Program, Time): There will be no changes in attitudes toward mental illness related to time of measurement due to the interaction of the effects of levels of treatment (attitude change mechanism) and Self Concept of the subjects. The null hypothesis for this interaction was retained for both Wayne Community College and Western Piedmont Community College. In other words, the interaction of Self Concept and Treatment did not change over time.

However, the Time variable did indicate a significant change in the subjects' attitudes on the factor authoritarianism, at Wayne Community College. As tested by the Duncan Multiple Range Test, the mean for the pretest (26.50) was significantly different from the posttest mean (25.15) and the delayed posttest mean (24.61); and the posttest was significantly different from the delayed posttest. In other words, the subjects became less authoritarian from pretest to posttest and from posttest to delayed posttest.

Factor D. Social Restrictiveness.

The results of the analysis of variance on the dependent variable, factor of Social Restrictiveness, are reported in Tables 7 and 8 for Wayne Community College and Western Piedmont Community College. High scores are reflective of more socially restrictive attitudes.

The null hypothesis was retained for both Wayne Community College and Western Piedmont Community College for Hypothesis 1 (Self Concept), Hypothesis 2 (Treatment Program), Hypothesis 3 (Self Concept and Treatment Program), and Hypothesis 4 (Self Concept, Treatment Program and Time).

However, the interaction of Treatment Program and Time for Social Restrictiveness was significant at Western Piedmont Community College. The interaction is shown in Figure 1 and the means are reported. The subjects exposed to the contact experiences became significantly less socially restrictive from the posttest to the delayed posttest, but not from pretest to posttest to delayed posttest as indicated by the Duncan Multiple Range Test. The subjects exposed to the information level of the Treatment Program became significantly less socially restrictive from the pretest to the posttest and the delayed posttest.

Table 7

Analysis of Variance of the OMI[a] Factor D (Social Restrictiveness) Scores for Wayne Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	6.28	< 1
Treatment Program (B)	3	118.50	1.54
A x B	6	146.72	1.90
Subjects within Groups	36	77.13	
Within Subjects			
Time (C)	2	3.73	< 1
A x C	4	10.00	< 1
B x C	6	18.69	1.39
A x B x C	12	15.18	1.13
C x Subjects within Groups	70	13.48	

[a] Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

Table 8

Analysis of Variance of the OMI[a] Factor D (Social Restrictiveness) Scores for Western Piedmont Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	147.60	1.06
Treatment Program (B)	3	33.53	< 1
A x B	6	67.25	< 1
Subjects within Groups	33	138.72	
Within Subjects			
Time (C)	2	17.24	1.89
A x C	4	8.70	< 1
B x C	6	26.50	2.91**
A x B x C	12	9.90	< 1
C x Subjects within Groups	66	9.11	

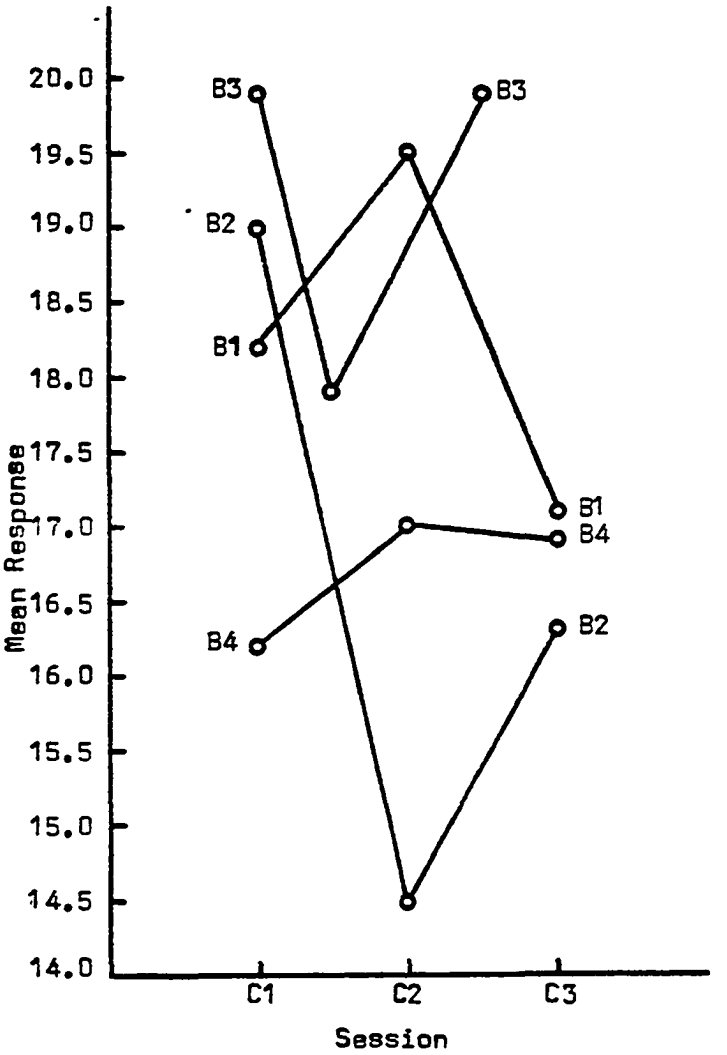
[a]Opinions About Mental Illness Scale

*$p < .05$

**$p \leq .01$

***$p < .001$

FIGURE 1
Mean Scores for the Interaction of Treatment and Time for Factor D (Social Restrictiveness) on the OMI Western Piedmont Community College



		TREATMENT				
		B-1	B-2	B-3	B-4	Mean
SESSION	C1	18.45	19.00	19.92	16.46	18.46
	C2	19.55	14.45	17.92	17.09	17.25
	C3	17.18	16.38	19.83	16.91	17.57
	Mean	16.60	16.61	19.22	16.82	

They became significantly more socially restrictive from the posttest to the delayed posttest.

The contact-plus-information subjects became significantly less socially restrictive from pretest to posttest, but they became significantly more socially restrictive from posttest to delayed posttest. The responses of subjects in the control group were not significant for any of the testing periods.

Factor B. Benevolence.

The results of the analysis of variance on the dependent variable, factor of Benevolence, are reported in Tables 9 and 10 for Wayne Community College and Western Piedmont Community College. High scores are reflective of more benevolent attitudes.

The following null hypotheses were retained for both Wayne Community College and Western Piedmont Community College: Hypothesis 1 (Self Concept), Hypothesis 2 (Treatment Program), Hypothesis 3 (Self Concept and Treatment Program), and Hypothesis 4 (Self Concept, Treatment Program, and Time).

However, the interaction of Self Concept and Time was significant for Wayne Community College. The interaction is shown in Figure 2 and the means are reported. As tested by the Duncan Multiple Range Test, the High Positive Self Concept Group responded in the same manner for all three testing periods. The Average Self Concept Group was significantly more benevolent at the delayed posttesting period when compared with their performance at the pretest and the posttest, but there was no difference in their performance from the pretest to the posttest periods. The Low Negative Self Concept Group was significantly more

Table 9

Analysis of Variance of the OMI[a] Factor B (Benevolence) Scores for Wayne Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	27.50	< 1
Treatment Program (B)	3	129.42	1.35
A x B	6		
Subjects within Groups	36	84.58	< 1
Within Subjects			
Time (C)	2	24.25	2.05
A x C	4	38.27	3.23*
B x C	6	7.58	0.64
A x B x C	12	7.40	0.62
C x Subjects within Groups	70	11.86	

[a] Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

Table 10

Analysis of Variance of the OMI[a] Factor B (Benevolence) Scores for Western Piedmont Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	269.23	2.71
Treatment Program (B)	3	74.27	< 1
A x B	6	225.54	2.27
Subjects within Groups	33	99.53	
Within Subjects			
Time (C)	2	5.95	< 1
A x C	4	16.99	< 1
B x C	6	31.37	1.29
A x B x C	12	18.53	< 1
C x Subjects within Groups	66	23.34	

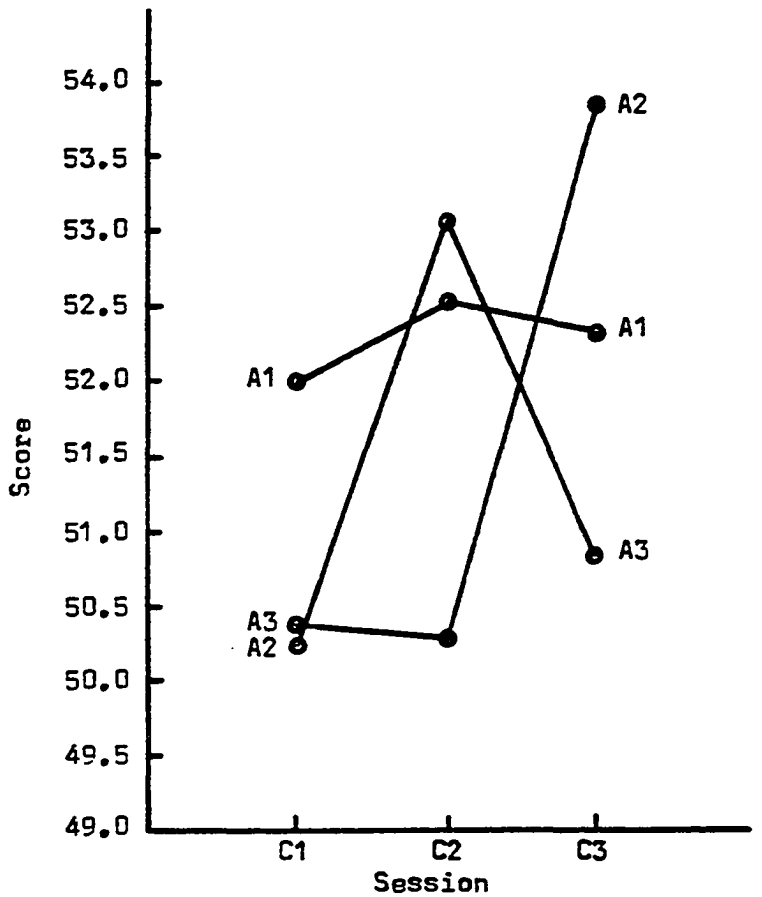
[a]Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

FIGURE 2
Mean Scores for the Interaction of Self Concept and Time for Factor B (Benevolence) on the OMI



		SESSION			
		C1	C2	C3	Mean
SELF CONCEPT	A1	52.00	52.53	52.31	52.28
	A2	50.39	50.28	53.88	51.52
	A3	50.23	53.08	50.85	51.39
	Mean	50.87	51.96	52.35	

benevolent from pretest to posttest, but became significantly less benevolent from the posttest to the delayed posttest. The difference between the pretest and the delayed posttest scores for this group was not significant.

Factor C. Mental Hygiene Ideology.

The results of the analysis of variance on the dependent variable, factor of Mental Hygiene Ideology, are reported in Tables 11 and 12 for both Wayne Community College and Western Piedmont Community College. High scores are reflective of the subjects viewing mental illness as being like any other type of illness and thus amenable to treatment. The null hypotheses for the main effects of Self Concept and Treatment on Mental Hygiene Ideology were retained for both Wayne Community College and Western Piedmont Community College. For Hypothesis 3, concerning the interaction of Self Concept and Treatment, the null hypothesis for the main effect on Mental Hygiene Ideology was retained for Wayne Community College, but was rejected for Western Piedmont Community College. The interaction is shown in Figure 3 and the means are reported.

At Western Piedmont Community College, the High Positive Self Concept Group was more amenable to the ideology of persons receiving treatment for mental illness in the same way as they would receive treatment for any other type of illness in the contact, information and contact-plus-information groups, but not in the control group. These subjects in the contact, information, and contact-plus-information groups all responded in the same positive direction; there were no significant differences between treatment groups.

Table 11

Analysis of Variance of the OMI[a] Factor C (Mental Hygiene Ideology) Scores for Wayne Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	16.01	< 1
Treatment Program (B)	3	85.40	1.40
A x B	6	46.77	< 1
Subjects within Groups	36		
Within Subjects			
Time (C)	2	7.93	< 1
A x C	4	3.87	< 1
B x C	6	3.87	< 1
A x B x C	12	12.02	< 1
C x Subjects within Groups	70		

[a]Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

Table 12

Analysis of Variance of the OMI[a] Factor C (Mental Hygiene Ideology) Scores for Western Piedmont Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	16.39	< 1
Treatment Program (B)	3	16.03	< 1
A x B	6	141.05	5.08*
Subjects within Groups	33	27.78	
Within Subjects			
Time (C)	2	29.56	3.01*
A x C	4	13.67	1.39
B x C	6	21.14	2.15
A x B x C	12	9.74	< 1
C x Subjects within Groups	66	9.82	

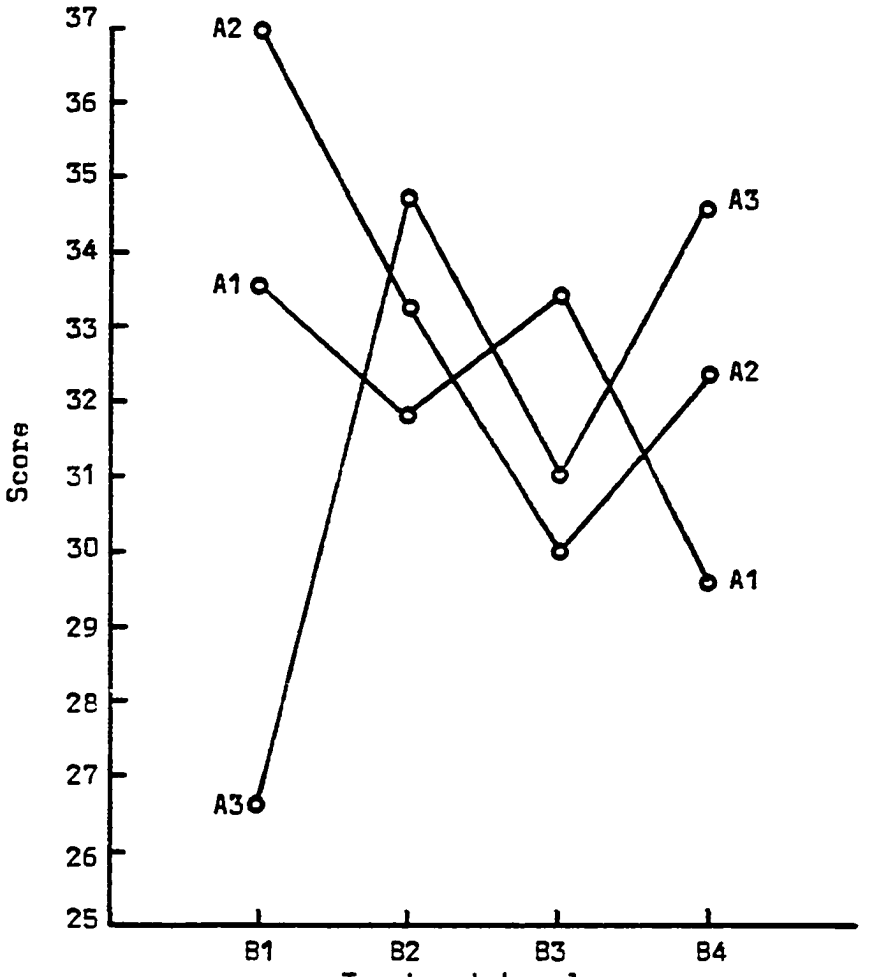
[a]Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

FIGURE 3
Mean Scores for the Interaction of Self Concept and Treatment for Factor C (Mental Hygiene Ideology) on the OMI
Western Piedmont Community College



SELF CONCEPT

TREATMENT PROGRAM		A1	A2	A3	Mean
	B1	33.72	37.00	26.73	32.48
	B2	31.93	33.11	34.93	33.32
	B3	33.55	30.00	31.00	31.52
	B4	29.62	32.72	34.94	32.43
	Mean	32.21	33.21	31.90	

For the subjects in the Average Self Concept Group, the contact experiences were significantly more favorable than the information only, contact-plus-information and control group experiences. The information only experiences were more favorable when compared with contact-plus-information experiences. There were no significant differences in the response of the subjects in the information only group and the control group.

The Low Negative Self Concept subjects responded significantly more favorably in their thinking relative to the treatment of mental illness in the information only and control groups when compared with subjects in the contact-plus-information groups. Furthermore, the subjects exposed to the contact-plus-information experiences reacted significantly more favorably than those exposed to the contact only experiences.

In addition, the main effect for the variable Time was also significant at Western Piedmont Community College. As tested by the Duncan Multiple Range Test, there were significant differences for the subjects between the pretest (mean = 31.02) and the posttest (mean = 32.42) and from the pretest to the delayed posttest (mean = 33.04); there were not significant differences from the posttest to the delayed posttest. In other words, the subjects' attitude toward mental illness is that it should be treated like any other illness, changed most from the pretest to the posttest but the change from posttest to delayed posttest was not very great.

Factor E. Interpersonal Etiology.

The results of the analysis of variance on the dependent variable, factor of Interpersonal Etiology, are reported in Tables 13 and 14 for both Wayne Community College and Western Piedmont Community College. High scores are reflective of attitudes and thoughts of subjects believing that emotional disturbance arises from interpersonal experiences, particularly those involving love and attention during childhood. Interpersonal Etiology is a more cognitive rather than an attitudinal factor (Cohen and Struening, 1964).

The following null hypotheses for the Factor E analysis were retained: Hypothesis 1 (Self Concept), Hypothesis 2 (Treatment Program), Hypothesis 3 (Self Concept and Treatment Program), and Hypothesis 4 (Self Concept, Treatment Program and Time) for both Wayne Community College and Western Piedmont Community College.

However, the main effect for Time was significant at Western Piedmont Community College. As tested by the Duncan Multiple Range Test, the pretest mean (16.57) was significantly different from both the posttest mean (18.00) and the delayed posttest mean (18.98). In essence, this meant that there was an increased tendency to believe from pretest to posttest and from pretest to delayed posttest that mental illness arises from the lack of appropriate interpersonal experiences, particularly those involving love and attention during childhood.

Attitude Toward Work

The results of the analysis of variance for the dependent variable, Attitude Toward Work, are reported in Tables 15 and 16 for both Wayne

Table 13

Analysis of Variance of the OMI[a] Factor E (Interpersonal Etiology) Scores for Wayne Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	115.10	2.23
Treatment Program (B)	3	131.04	2.53
A x B	6	26.77	< 1
Subjects within Groups	36	51.71	
Within Subjects			
Time (C)	2	9.12	< 1
A x C	4	18.05	1.84
B x C	6	18.97	1.94
A x B x C	12	10.57	1.08
C x Subjects within Groups	70	9.79	

[a]Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

Table 14

Analysis of Variance of the OMI[a] Factor E (Interpersonal Etiology) Scores for Western Piedmont Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	149.44	2.51
Treatment Program (B)	3	100.34	1.69
A x B	6	34.78	< 1
Subjects within Groups	33	59.55	
Within Subjects			
Time (C)	2	77.17	6.33**
A x C	4	17.78	1.46
B x C	6	11.32	< 1
A x B x C	12	8.91	< 1
C x Subjects within Groups	66	12.20	

[a]Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

Table 15

Analysis of Variance of the ATWPS[a] Attitude Toward Work Scores for Wayne Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	80.55	1.51
Treatment Program (B)	3	136.08	2.56
A x B	6	89.96	1.67
Subjects within Groups	36	53.19	
Within Subjects			
Time (C)	2	71.62	1.71
A x C	4	17.41	< 1
B x C	6	64.47	1.54
A x B x C	12	36.34	< 1
C x Subjects within Groups	70	41.87	

[a]Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

Table 16

Analysis of Variance of the ATWPS[a] Attitude Toward Work Scores for Western Piedmont Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	82.17	< 1
Treatment Program (B)	3	196.10	2.15
A x B	6	177.99	1.96
Subjects within Groups	33	91.06	
Within Subjects			
Time (C)	2	5.22	< 1
A x C	4	28.13	1.22
B x C	6	25.41	1.10
A x B x C	12	32.62	1.42
C x Subjects within Groups	66	23.03	

[a]Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

Community College and Western Piedmont Community College. High scores are reflective of a more favorable attitude toward work in community mental health.

The following null hypotheses for the attitude toward work variable: Hypothesis 5 (Self Concept), Hypothesis 6 (Treatment Program), Hypothesis 7 (Self Concept and Treatment Program), and Hypothesis 8 (Self Concept, Treatment Program and Time) were retained for both Wayne Community College and Western Piedmont Community College. There were no other significant main effects for the analysis of variance.

Attitude Toward Professionals

The results of the analysis of variance are reported in Tables 17 and 18 for Wayne Community College and Western Piedmont Community College. The dependent variable assessed was the Attitude Toward Professionals in community mental health. High scores are reflective of more positive attitudes toward professionals.

The null hypotheses for the Attitude Toward Professionals variable for Hypothesis 9 (Self Concept), Hypothesis 10 (Treatment Program), Hypothesis 11 (Self Concept and Treatment) for Wayne Community College, and Hypothesis 12 (Self Concept, Treatment Program, and Time) were retained for both Wayne Community College and Western Piedmont Community College. At Western Piedmont Community College, the null hypothesis for Hypothesis 10 was rejected.

As stated above, the null hypothesis for Treatment Program was rejected for Western Piedmont Community College. As tested by the Duncan Multiple Range Test, the control group subjects (mean = 52.60) were significantly more favorable in attitudes toward professionals when

Table 17

Analysis of Variance of the ATWPS[a] Attitude Toward Professionals Scores for Wayne Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	381.00	1.39
Treatment Program (B)	3	407.76	1.49
A x B	2	425.64	1.55
Subjects within Groups	36	273.88	
Within Subjects			
Time (C)	2	403.17	4.63**
A x C	4	23.10	< 1
B x C	6	118.75	1.36
A x B x C	12	77.79	< 1
C x Subjects within Groups	70	87.15	

[a]Opinions About Mental Illness Scale

*$p < .05$

**$p < .01$

***$p < .001$

Table 18

Analysis of Variance of the ATWPS[a] Attitude Toward Professionals Scores for Western Piedmont Community College

Source	df	MS	F
Between Subjects			
Self Concept (A)	2	801.82	2.85
Treatment Program (B)	6	1179.54	4.20**
A x B	3	146.03	< 1
Subjects within Groups	33	281.12	
Within Subjects			
Time (C)	2	623.10	7.20**
A x C	4	81.71	< 1
B x C	6	154.15	1.78
A x B x C	12	116.64	1.35
C x Subjects within Groups	66	86.59	

[a]Opinions About Mental Illness Scale

*p < .05

**p < .01

***p < .001

compared with the experiences in the contact only (mean = 40.63), information only (mean = 37.91), and contact-plus-information (mean = 38.62) groups. There were no significant differences between the contact only, the information only, and contact-plus-information levels of the Treatment Program.

In addition, the main effect for Time was significant in relation to Attitudes Toward Professionals at both Wayne Community College and Western Piedmont Community College. At Wayne Community College, the subjects became significantly more negative toward professionals from the pretest (mean = 47.54) to the posttest (mean = 45.52), and from the posttest to the delayed posttest (mean = 41.84).

The subjects exhibited similar patterns of performance at both Wayne Community College and Western Piedmont Community College. Groups at both schools developed increasingly negative attitudes toward professionals over the three time periods.

Attitudes Toward Mental Illness, Work, and Professionals-- Comparison By Race: Wayne Community College

A racial group comparison was not originally considered in this research. However, due to the composition of the sample population at Wayne Community College (i.e. 50:50 ratio of Black and White subjects), it was considered desirable to analyze the data by Race because findings from previous research studies have indicated differences in reference to the self concept of Blacks and Whites. Findings from research studies have revealed that Blacks usually have a more negative self concept than Whites and they are more authoritarian (Hauser, 1971; Kardiner & Ovesey, 1962; Pettigrew, 1964; Powell, 1973; Willie, Kramer &

Brown, 1973). Therefore, a four way analysis of variance with Race as a fourth factor was computerized.

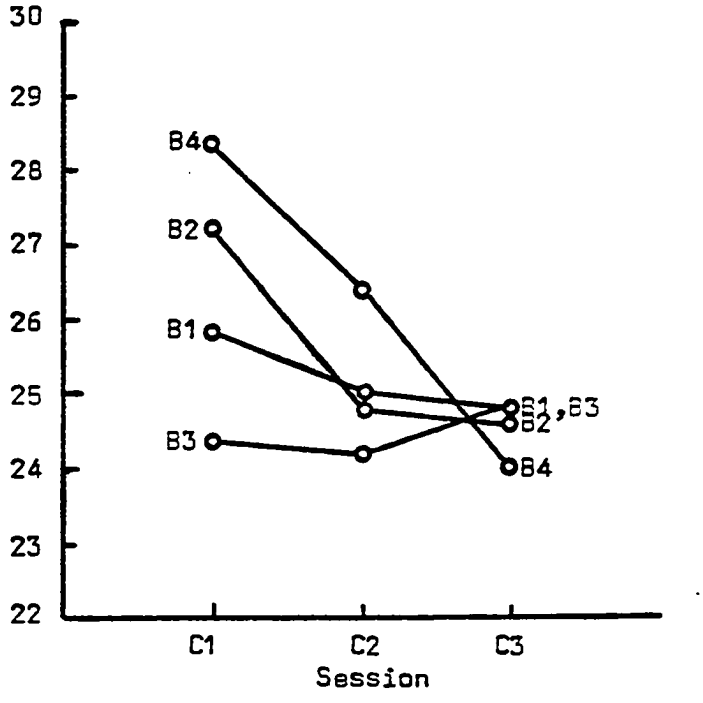
When a preliminary analysis of the data was completed, Race was found to be a significant variable in certain instances. The four way analysis of variance showed significant main effects and interactions on variables which had not shown significance on the three way analysis of variance. However, there is a possibility of invalidity in the analysis of these findings due to the low number of subjects in some cells. Therefore, the results are reported somewhat tentatively. All significant main effects and interactions will be discussed in this section.

Factor A. Authoritarianism.

The main effects of the variable Time was significant in relation to authoritarianism in the four way analysis of variance as it was in the three way analysis of variance ($F = 4.24$, $P < .05$). Therefore, its significance will not be discussed again, except to say that the subjects became less authoritarian from pretest to posttest and from posttest to delayed posttest.

The interaction of The Treatment Program and Time was also significant ($F = 2.38$, $P < .05$). The interaction is shown in Figure 4 and the means are reported. For the contact only group as tested by the Duncan Multiple Range Test, there were no significant differences between the three testing periods. For the information only group, the subjects became less authoritarian from pretest to posttest and from posttest to delayed posttest. The behavior of the subjects in the contact-plus-information group mirrors that of the subjects in the

FIGURE 4
Mean Scores for the Interaction of Treatment and Time
for Factor A (Authoritarianism) on the OMI
Wayne Community College



		TREATMENT				
		B1	B2	B3	B4	Mean
SESSION	C1	25.91	27.33	24.32	28.50	26.52
	C2	25.00	24.91	24.21	26.50	25.16
	C3	24.83	24.60	24.83	24.23	24.64
	Mean	25.26	25.61	24.45	26.41	

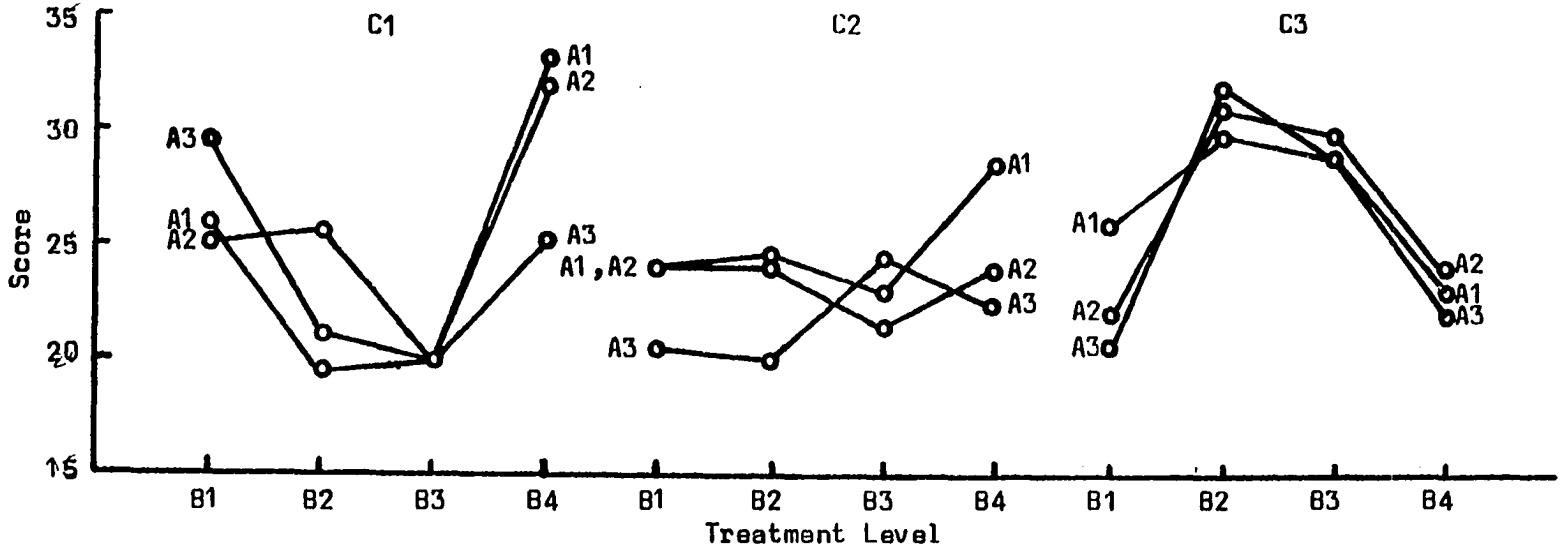
contact only group; that is, there were no significant differences between the three testing periods. The subjects in the control group exhibited the most striking performance of all the groups as they displayed an inverse linear relationship, becoming less authoritarian with each testing period.

The interaction of Self Concept, Treatment Program and Time was significant ($F = 2.14$, $P < .05$). This interaction is shown in Figure 5 and the means are reported. As tested by the Duncan Multiple Range Test, the High Positive Self Concept subjects were significantly less authoritarian in the contact-plus-information group than the subjects in the contact only, information only, and control groups at the time of the pretest, and subjects in the contact only and information only groups were also significantly less authoritarian than those in the control group.

The Average Self Concept subjects were significantly less authoritarian in the information only group than subjects exposed to the contact only and control group experiences. Subjects in the contact-plus-information group were less authoritarian than those in the contact only and control groups, and the contact only group subjects were less authoritarian than the control group subjects. In other words, the control group subjects were the most authoritarian, followed by the contact only group subjects. There were no significant differences between the information only and contact-plus-information group subjects.

The Low Negative Self Concept subjects were significantly less authoritarian in the contact-plus-information group when compared to the contact only and control group subjects. Subjects in the contact group

FIGURE 5
Mean Scores for the Interaction of Self Concept, Treatment, and Time for Factor A (Authoritarianism) on the OMI
Wayne Community College



		SELF CONCEPT											
		C1				C2				C3			
		A1	A2	A3	Mean	A1	A2	A3	Mean	A1	A2	A3	Mean
TREATMENT	B1	25.00	25.60	28.00	26.20	26.84	26.38	23.81	25.66	26.33	22.33	21.00	23.22
PROGRAM	B2	25.32	19.50	21.72	22.18	27.83	26.50	23.20	25.84	30.00	31.00	32.50	31.17
	B3	20.60	20.00	20.20	20.27	25.33	24.00	27.33	25.55	28.00	29.50	28.84	28.78
	B4	30.00	29.72	25.33	28.35	31.80	26.60	25.00	27.80	23.33	24.00	22.32	23.22
	Mean	25.23	23.70	23.81		27.95	26.86	24.84		26.92	26.83	26.16	

were significantly more authoritarian than those in the information only and control groups. There were no significant differences between the information only and the contact-plus-information groups.

During the posttest period, the High Positive Self Concept subjects were significantly less authoritarian in the contact-plus-information group when compared with the information only and control groups. The control group subjects were significantly more authoritarian when compared with either the contact only or information only groups. As a matter of fact, the control group subjects again were the most authoritarian. Between the subjects in the contact only and contact-plus-information groups, the differences were not statistically significant.

The Average Self Concept subjects receiving the contact-plus-information treatment were significantly less authoritarian than those receiving information only, contact-plus-information and control groups. There were no significant differences between the attitudes of the subjects in the information only, contact-plus-information and control groups.

The Low Negative Self Concept subjects also had a very interesting pattern of responding. There were significantly less authoritarian in the contact only, information only and control groups. In other words, the contact-plus-information group was the most authoritarian.

At the time of the delayed posttest, the High Positive Self Concept group subjects were significantly less authoritarian in the control group when compared with the subjects in the contact only, information only, and contact-plus-information groups. The subjects in the contact only and the contact-plus-information groups were significantly less

authoritarian than those in the information only group (Duncan Multiple Range Test). However, there were no significant differences between the High Positive Self Concept subjects in the contact only and contact-plus-information groups.

The Average Self Concept subjects were significantly less authoritarian in the contact only and control groups when compared with the subjects exposed to the information only and the contact-plus-information levels of the Treatment Program. The subjects exposed to the contact-plus-information experiences were significantly less authoritarian when compared to the subjects exposed to the information only experiences.

Comparing all of the three self concept groups over time, some rather interesting findings emerged. From the pretest to the posttest, the High Positive Self Concept subjects became significantly more authoritarian on all treatment levels. From the posttest to the delayed posttest, this continued to be true except for the High Positive Self Concept subjects in the control group who became significantly less authoritarian than they were at the pretest and posttest. The Average Self Concept subjects also became significantly less authoritarian from pretest to posttest, except those in the control group who became less authoritarian as had the High Positive Self Concept Group. From the posttest to the delayed posttest, the Average Self Concept subjects continued to become significantly more authoritarian except for those subjects in the contact only group who became significantly less authoritarian, and again those in the control group who continued to become significantly less authoritarian.

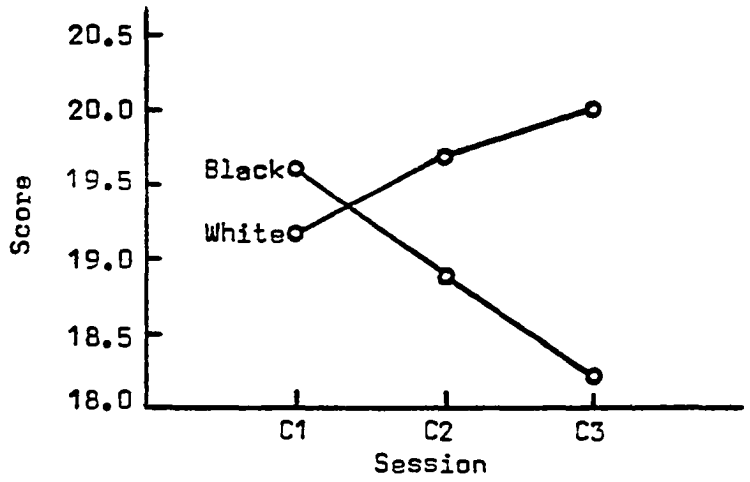
For the Low Negative Self Concept subjects, those in the information only and the contact-plus-information groups followed the pattern of the High Positive Self Concept and Average Self Concept Groups--becoming more authoritarian from pretest to posttest. The subjects in the control group remained at the same level of authoritarianism, but the subjects in the contact only group became significantly less authoritarian with each successive testing period.

From pretest to posttest and from posttest to delayed posttest, the pattern of becoming more authoritarian continued with all three self concept groups except the Average Self Concept and the Low Negative Self Concept Groups who were in the control group and contact only group respectively. These subjects became significantly less authoritarian with each testing period. The High Positive Self Concept Group subjects were not significantly different in their attitudes from pretest to posttest in the control group, but they were significantly less authoritarian from posttest to delayed posttest.

Factor D. Social Restrictiveness.

The interaction of Race and Time was significant ($F = 3.23$, $P < .05$). Figure 6 illustrates the interaction and reports the means for the groups. Black subjects became less socially restrictive over the three testing periods, but the difference was only significant from the pretest to the delayed posttest. The White subjects became more socially restrictive from pretest to posttest; however, no other differences were significant (Duncan Multiple Range Test).

FIGURE 6
Mean Scores for the Interaction of Race and Time for Factor D (Social Restrictiveness) on the OMI
Wayne Community College



		RACE		
		Black	White	
		B	W	Mean
SESSION	C1	19.52	19.20	19.36
	C2	18.95	19.73	19.34
	C3	18.23	20.00	19.12
	Mean	18.90	19.64	

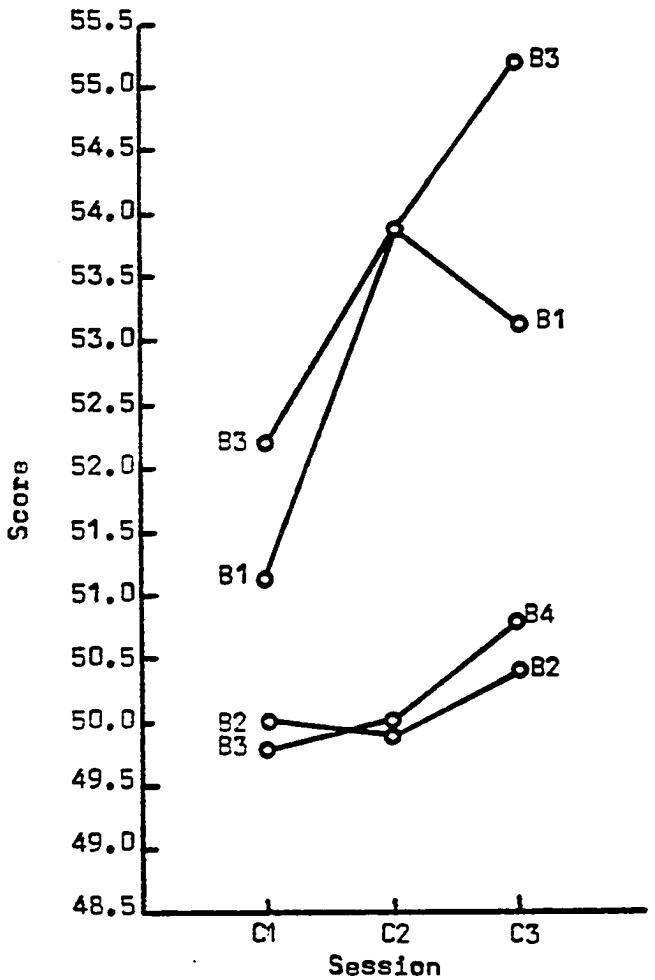
Factor B. Benevolence.

The factor of the dependent variable assessed was benevolence. High scores are reflective of more benevolent attitudes. The significant main effects and interactions were examined.

The interaction of the Treatment Program and Time was significantly related to the attitude of Benevolence ($F = 2.50$, $P < .05$). Figure 7 illustrates the interaction and reports the means for the groups. In relation to the Time variable, there were no differences between the subjects in the control group from pretest to posttest, from posttest to delayed posttest and from pretest to delayed posttest (Duncan Multiple Range Test). The subjects in the information only group showed a slight drop in benevolence from posttest to delayed posttest, but these differences were not significant. Also, the subjects in the contact-plus-information group became significantly more benevolent from pretest to posttest and from pretest to delayed posttest. The subjects in the control group were similar in attitudes to those in the information only group: there were no significant differences in performance over the three testing periods.

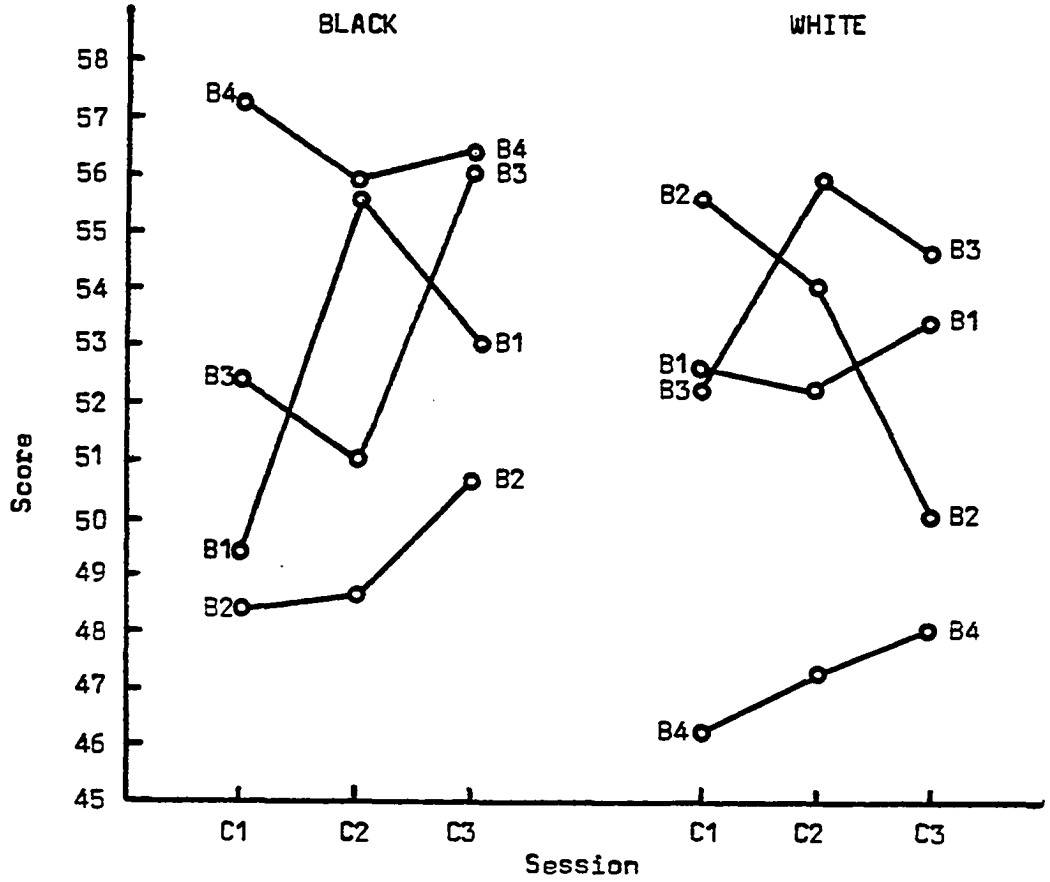
The interaction of Treatment Program, Time and Race was significant in reference to Benevolence ($F = 2.83$, $P < .05$). The interaction is shown in Figure 8 and the means are reported. At pretest, the Black subjects in the control group were significantly more benevolent than those in the contact only, information only and contact-plus-information groups; those in the contact only and information only groups were not significantly different from each other. At the posttest, the Black subjects in the control and contact only groups were not different in beuevolence; however both groups were significantly

FIGURE 7
Mean Scores for the Interaction of Treatment and Time
for Factor B (Benevolence) on the OMI
Wayne Community College



		TREATMENT				
		B1	B2	B3	B4	Mean
SESSION	C1	51.25	50.08	52.25	50.08	50.92
	C2	53.58	49.92	53.83	50.00	51.83
	C3	53.25	50.40	55.17	50.75	52.39
	Mean	52.69	50.13	53.75	50.28	

FIGURE 8
Mean Scores for the Interaction of Treatment, Race, and Time
for Factor B (Benevolence) on the OMI
Wayne Community College



		SESSION							
		BLACK				WHITE			
		C1	C2	C3	Mean	C1	C2	C3	Mean
TREATMENT	B1	49.40	55.40	53.00	52.60	52.62	52.33	53.42	52.79
PROGRAM	B2	48.22	48.63	50.50	49.12	55.72	54.00	50.00	53.24
	B3	52.40	51.00	56.00	53.13	52.14	55.92	54.62	54.23
	B4	57.00	55.84	56.25	56.36	46.23	47.12	48.00	47.12
	Mean	51.76	52.72	53.94		51.68	52.34	51.51	

greater in benevolence than information only and contact-plus-information. At the delayed posttesting period, the Black subjects in the control group were significantly more benevolent than subjects in the information group and contact only group; subjects in the contact-plus-information groups were similar in performance to the control group. Subjects in the contact only group were more significantly benevolent than those subjects in the information group (Duncan Multiple Range Test).

In general, across the three testing periods, the Black subjects became more benevolent as a result of the contact only group experiences,the information only, and the contact-plus-information experiences. Across the three testing periods, the subjects in the control group, while more benevolent, did not change to any great extent. Following all treatment, contact only and control experiences appeared to be most favorable of benevolent attitudes.

The White subjects, during the pretest, were significantly more benevolent in the information only group when compared with the treatment levels of contact only, contact-plus-information, and control group experiences. Contact only and contact-plus-information experiences appeared to significantly result in more benevolent attitudes than control group experiences. At the posttest, subjects in the contact-plus-information group were significantly more benevolent than those in the contact only, information only and control groups. The information only group subjects were significantly more benevolent than control group and contact only group subjects; the contact only subjects were significantly more benevolent than the control group subjects.

During the delayed posttest period, the contact only and contact-plus-information subjects were more significantly benevolent than either the information only or control group.

For the White subjects, across the three testing periods, there appeared to be increases in benevolence for contact only, information only and control conditions. The information only group decreased in benevolence. Immediately after treatment (at posttest), the three treatment levels were generally more effective than the control experience.

In comparing the Black and White subjects, there are definite differences in their patterns of responding to the Treatment Program over time as well as similarities. The White subjects appeared to respond to the control condition as expected with lower benevolence while the Black subjects responded with greater benevolence under that condition. A similarity between Blacks and Whites was the relative superiority of contact-plus-information at the delayed posttest.

Factor C. Mental Hygiene Ideology.

This factor of the dependent variable (Factor C), attitude toward mental illness implies that mental illness is like any other type of illness and thus amenable to treatment. High scores are reflective of subjects adhering to this belief about mental health. There were no significant main effects or interactions as indicated by the analysis of variance.

Factor E. Interpersonal Etiology.

The factor of the dependent variable, attitude toward mental illness, assessed was Interpersonal Etiology. The main effects and

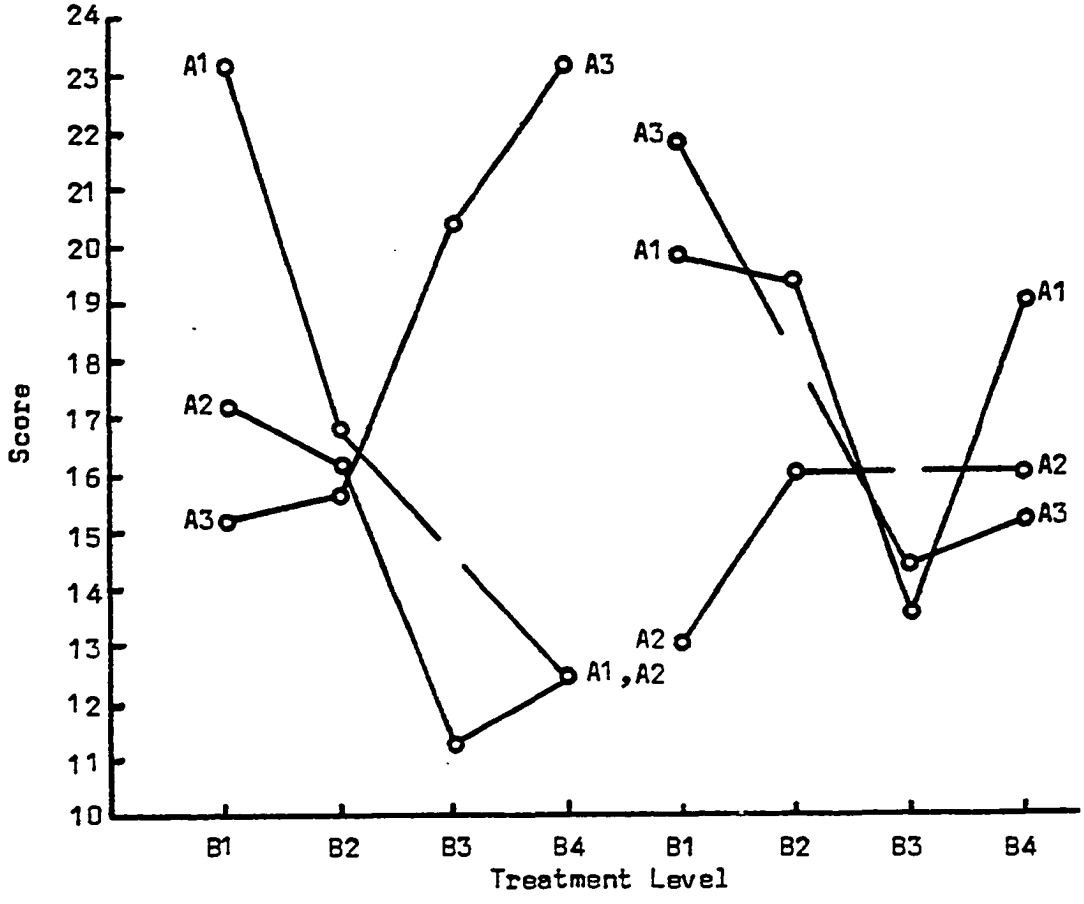
interactions were examined. On this more cognitive attitude, high scores are reflective of subjects believing that emotional disturbance arises from interpersonal experiences, particularly those involving love and attention during childhood.

The interaction of Self Concept, Treatment Program and Race was significant ($F = 3.10$, $P < .05$), in relation to Interpersonal Etiology. The interaction is shown in Figure 9 and the means are reported. As tested by the Duncan Multiple Range Test, the Black subjects who had a high positive self concept in the contact only group showed greater belief that mental illness results more from a lack of love and attention in childhood than those subjects in the information only and control groups; the subjects in the information only group were significantly higher in this belief than those subjects in the contact-plus-information group.

The Black subjects with average self concepts in the contact only and information only groups were also significantly greater in this attitude than subjects in the contact-plus-information and control groups (Duncan Multiple Range Test). However, there were no differences in the beliefs held by the subjects in the contact only and information only groups.

Black subjects with low negative self concepts appeared to have significantly stronger attitudes as a result of the contact-plus-information and control experiences when compared with contact only and information only experiences. There were no significant differences between the responses of the groups exposed to the contact-plus-information and control group experiences. The Black subjects in all

FIGURE 9
Mean Scores for the Interaction of Self Concept, Treatment, and Race for Factor E (Interpersonal Etiology) on the OMI
Wayne Community College



		SELF CONCEPT							
		BLACK				WHITE			
		A1	A2	A3	Mean	A1	A2	A3	Mean
TREATMENT	B1	23.33	17.23	15.33	18.63	19.91	13.00	21.83	18.25
PROGRAM	B2	16.83	16.21	15.72	16.25	19.40	16.00		17.84
	B3		11.44	20.33	15.88	13.52		14.22	13.80
	B4	12.33	12.33	23.33	16.00	19.00	16.00	15.11	16.70
	Mean	17.50	14.30	18.68		17.96	15.00	17.05	

three self concept groups responded differently to the varied levels of treatment.

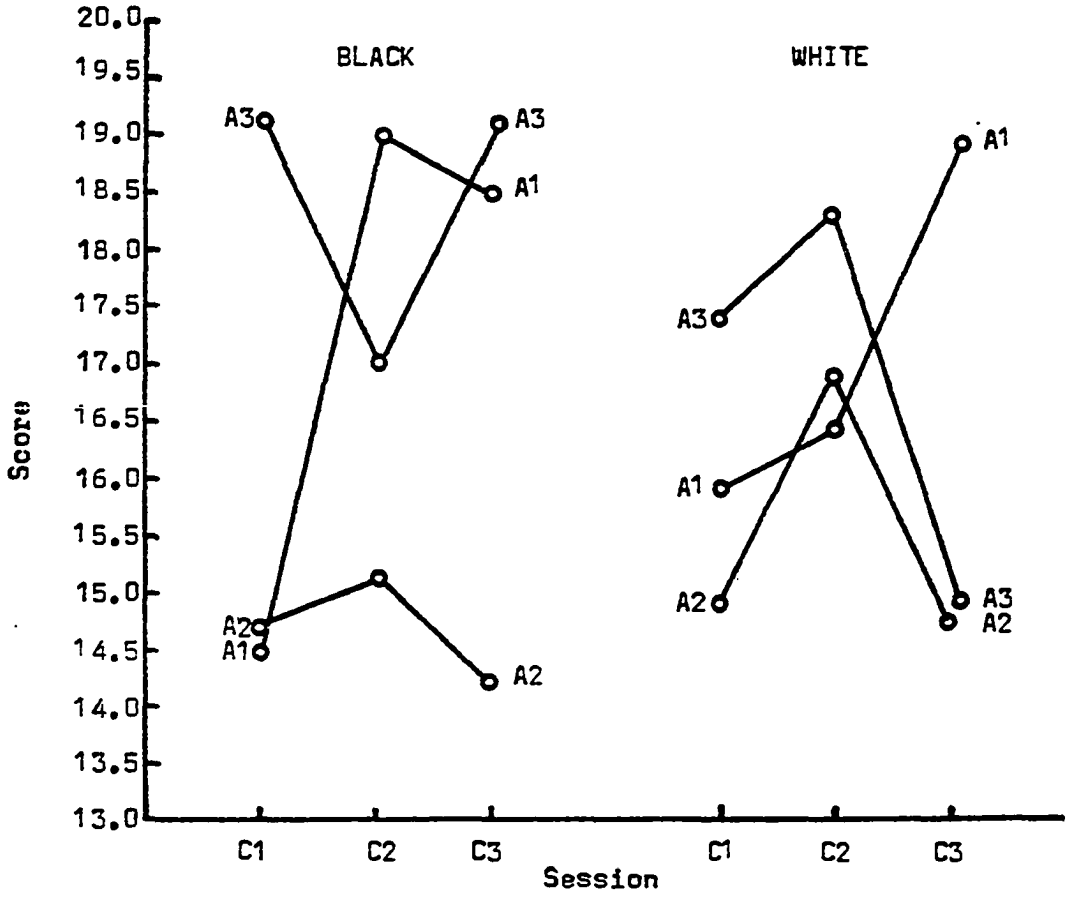
The White subjects in the High Positive Self Concept Group showed significantly greater agreement with this belief regarding the causes of mental illness when they were exposed to contact only and information only experiences when compared to contact-plus-information experiences. There were no significant differences between the subjects in the contact only, information only and control groups.

The White subjects with average self concepts responded in the same way to all levels of the Treatment Program. This was not the situation, however, with the White subjects with the low negative self concepts. The latter subjects in the contact only group showed significantly greater belief in Interpersonal Etiology than those subjects in the contact-plus-information and control groups. There were no significant differences between any of the other treatment levels.

Similar to the Black subjects in the three self concept groups, the White subjects in the three self concept groups responded differently to the four treatment levels, but not in the same manner.

The interaction of Self Concept, Race and Time was significant ($F = 2.79$, $P < .05$), in relation to Interpersonal Etiology. In other words, the effect of self concept over time on Interpersonal Etiology was different for Blacks and Whites. The interaction is shown in Figure 10 and the means are reported. The Black subjects in the High Positive Self Concept Group showed significantly greater belief in Interpersonal Etiology from pretest to posttest and from pretest to delayed posttest, but not from posttest to delayed posttest (Duncan

FIGURE 10
Mean Scores for the Interaction of Self Concept, Race, and Time on the OMI
Wayne Community College



		SESSION							
		BLACK				WHITE			
		C1	C2	C3	Mean	C1	C2	C3	Mean
SELF CONCEPT	A1	14.50	19.00	18.50	17.33	15.84	16.84	18.91	17.20
	A2	14.53	15.23	14.33	14.70	14.80	16.80	14.60	15.60
	A3	19.22	17.00	19.22	18.48	17.41	18.32	14.91	16.88
	Mean	16.08	17.08	17.35		16.02	17.31	16.14	

Multiple Range Test). There were no significant differences in the way the subjects in the Average Self Concept Group responded over time. The Black subjects in the Low Negative Self Concept Group significantly decreased in belief in Interpersonal Etiology from pretest to posttest. However, these same subjects significantly increased from posttest to delayed posttest. Again, the three Black self concept groups responded in different ways.

The White subjects in the High Positive Self Concept Group became significantly more convinced of their beliefs as to the etiology of emotional disturbances from pretest to delayed posttest and from posttest to delayed posttest, but not from pretest to posttest. The White subjects in the Average Self Concept Group mirrored the performance of the Black High Positive Self Concept subjects. However, the White Low Negative Self Concept subjects presented a different pattern. There was no change in attitude for this group between pre and posttest. There was a significant drop in scores from posttest to delayed posttest.

In comparing the three Black self concept groups with the three White self concept groups, the data present some similarities and some differences. The pattern of the Black subjects in the Average Self Concept Group resembled that of the White subjects in the Average Self Concept Group; while the other self concept groups responded differently.

Attitude Toward Work

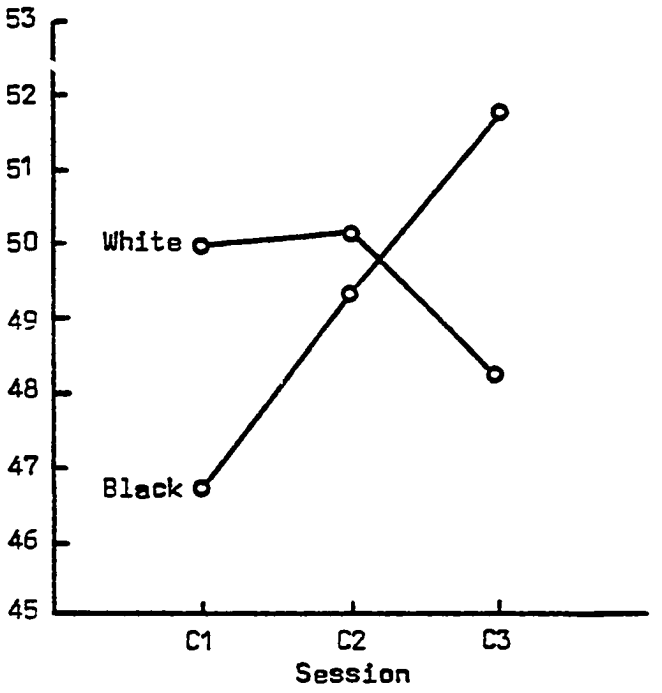
The dependent variable, Attitude Toward Work, was assessed, and significant main effects and interactions were examined. High scores

are reflective of subjects being more positive in their attitudes toward work in community mental health.

The interaction of Race and Time was significant ($F = 6.46$, $P < .01$) as related to the dependent variable, Attitude Toward Work. The interaction is shown in Figure 11 and the means are reported. The Black subjects exhibited a positive linear relationship toward work over the three testing periods. However, only the difference between the pretest and the delayed posttest was significant (Duncan Multiple Range Test). The White subjects did not change from pretest to posttest, but they did change significantly, in a negative direction, from the posttest to the delayed posttest. In other words, the White subjects became more negative toward work in community mental health from posttest to the delayed posttest.

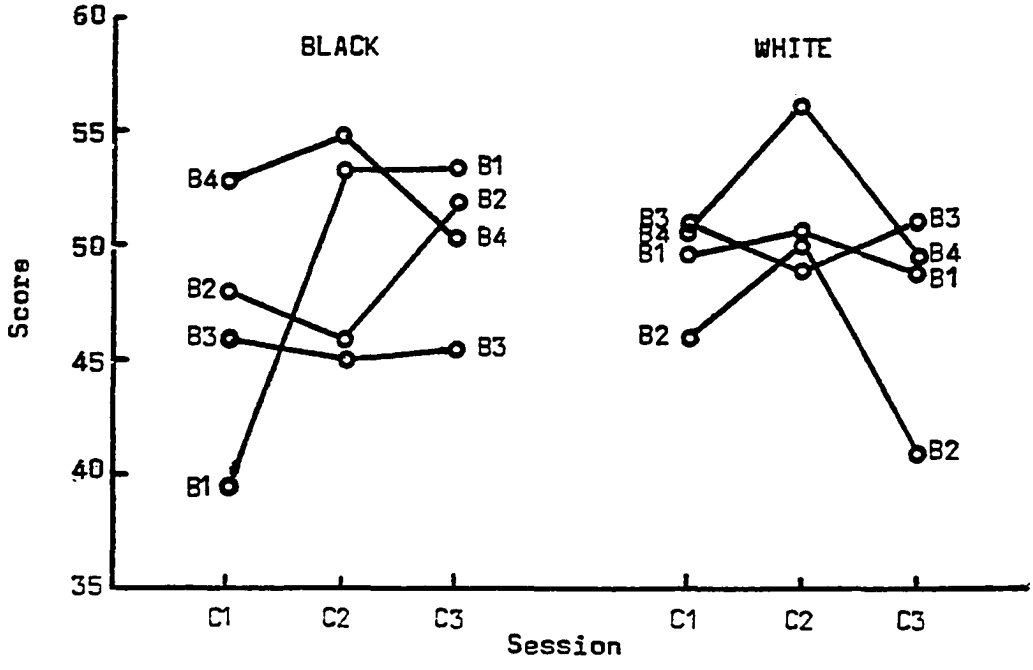
The interaction of the Treatment Program, Race and Time was also significant ($F = 2.59$, $P < .05$) in relation to the dependent variable, Attitude Toward Work. In other words, the relative effectiveness of the treatments over time, was different for Blacks and Whites. The interaction is shown in Figure 12 and the means are reported. During the pretest, the Black subjects were significantly more positive in their attitudes toward work in the control group when compared with subjects in the contact only, information only, and contact-plus-information groups. Subjects in the information only and contact-plus information groups were significantly more positive in their attitudes toward work when compared with subjects in the contact only group. There were no significant differences between the attitudes of the subjects in the other groups.

FIGURE 11
Mean Scores for the Interaction of Race and Time
for the ATWPS: Attitude Toward Work
Wayne Community College



		RACE		
		Black	White	
		B	W	Mean
SESSION	C1	46.82	50.00	48.41
	C2	49.21	50.08	49.64
	C3	51.82	48.41	50.12
	Mean	49.28	49.50	

FIGURE 12
Mean Socres for the Interaction of Treatment, Race, and Time
for the ATWPS: Attitude Toward Work
Wayne Community College



		SESSION							
		BLACK				WHITE			
		C1	C2	C3	Mean	C1	C2	C3	Mean
TREATMENT	B1	39.40	55.40	53.00	49.27	52.62	52.33	53.42	52.79
PROGRAM	B2	48.22	48.63	50.50	49.12	55.72	54.00	50.00	53.24
	B3	52.40	51.00	56.00	53.13	52.14	55.92	54.62	54.23
	B4	57.00	55.84	56.25	56.36	46.23	47.12	48.00	47.12
	Mean	49.26	52.72	53.94		51.68	52.34	51.51	

At the posttest, the Black subjects in the contact only and control groups were significantly more positive in their attitudes toward work when compared with information only and contact-plus-information groups. Significant differences were not found between the other groups (Duncan Multiple Range Test). At the delayed posttest, the Black subjects exposed to the contact only, information only and control group experiences were significantly more positive in their attitudes toward work when compared with those in the contact-plus-information group. As tested by the Duncan Multiple Range Test, there were not any other significant differences between the levels of treatment.

In comparing the four groups exposed to the different levels of the Treatment Program over time, the findings indicate that the subjects in the contact only group made the greatest positive gain in attitude toward work (Duncan Multiple Range Test). Subjects in the control group also significantly increased their positive attitudes toward work over the three testing periods. Subjects in the information only and contact-plus-information groups became more negative in their attitudes toward work from pretest to posttest, but subjects in the information only group made significantly more positive increases in their attitudes toward work from posttest to delayed posttest. This, however, was not true of the subjects in the contact-plus-information group; they remained at the same level.

At pretest, the White subjects had the most positive attitudes toward work in the control group when compared with the other three groups (i.e. information only, contact only, contact-plus-information). There were no other significant differences between the groups. During

the posttest, the subjects in the contact-plus-information group significantly had the most positive attitudes toward work when compared to other treatments. The attitudes between the other groups were not significantly different (Duncan Multiple Range Test). During the delayed posttest, subjects in the information only, contact-plus-information, and the control groups had significantly more positive attitudes toward work than those subjects in the information only group. Differences between the attitudes in the former three treatment groups were not significant, however.

Comparing each of the levels of the Treatment Program across the three testing periods for Whites provided some interesting patterns. From pretest to posttest, all groups became more positive in their attitudes toward work except the control group which became more negative. However, the only significant differences were between the attitudes of the subjects in the information only and the contact-plus-information groups. From the posttest to the delayed posttest, all subjects became more negative in their attitudes toward work except those in the control group. However, only the differences for the subjects in the information only and contact-plus-information groups were significant. The general trend for the White subjects on all of the Treatment levels was to increase positively in their attitudes toward work from pretest to posttest, then to decrease in their attitudes toward work from posttest to delayed posttest.

In checking the findings between the Black and White subjects, there were not too many similarities in their patterns of responding. Black subjects exposed to the levels of the Treatment Program,

information only, and contact-plus-information, became more negative in their attitudes toward work from pretest to posttest, and more positive in their attitudes from posttest to delayed posttest; while the White subjects exposed to these same experiences became more positive in their attitudes toward work from the pretest to posttest, but more negative from the posttest to delayed posttest. In summary, the White subjects increased in their attitudes toward work from pretest to posttest, then decreased from posttest to delayed posttest. The Black subjects in information only and contact-plus-information decreased in their attitudes toward work from pretest to posttest, while the Black subjects in the contact only and control groups increased in their attitudes toward work. The reverse was true of the groups from posttest to delayed posttest.

The basic similarity between the two groups was that each group changed over the three testing periods. The levels of the Treatment Program which appeared to be most effective in changing the attitudes of the Black subjects in a positive direction were the contact only and control group experiences. The levels of the Treatment Program which appeared to be most effective for the White subjects in changing their attitudes toward work in a positive direction were contact-plus-information and control group experiences.

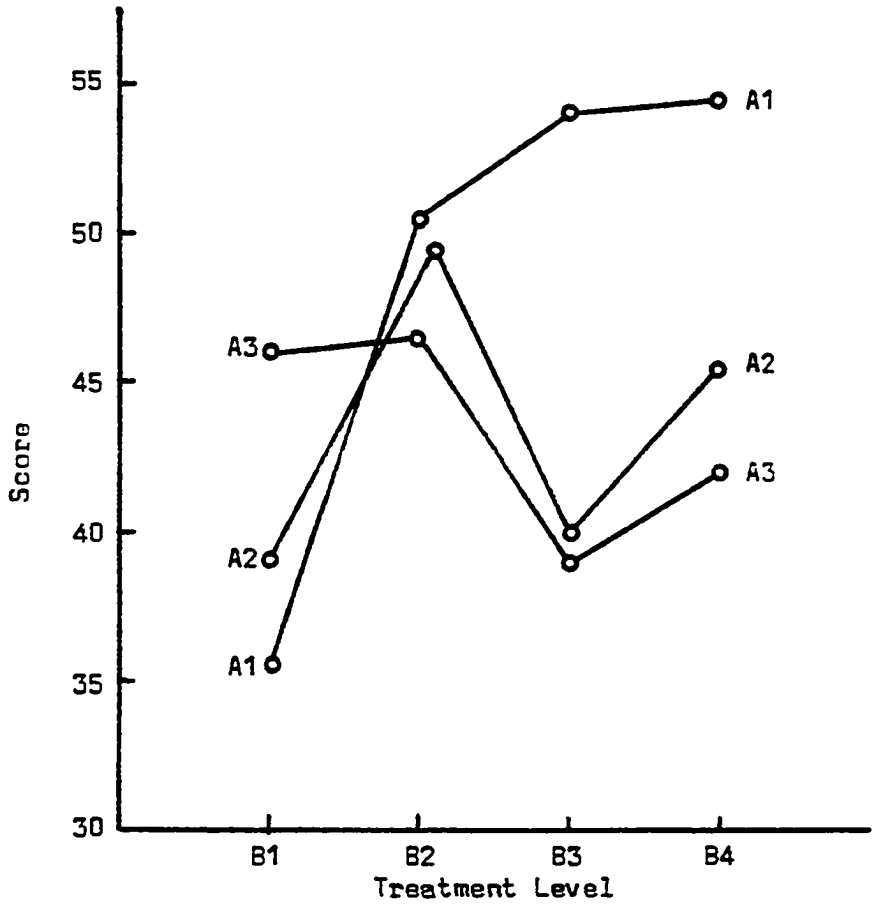
Attitude Toward Professionals

The dependent variable assessed was Attitude Toward Professionals. High scores were reflective of more positive attitudes. Significant main effects and interactions were examined.

The interaction of Self Concept and Treatment Program was significant ($F = 2.72$, $P < .05$) in relation to Attitude Toward Professionals. Figure 13 illustrates this interaction and the means are reported. As tested by the Duncan Multiple Range Test, the subjects in the High Positive Self Concept Group made significant changes when exposed to the treatment levels information only, contact-plus-information, and control group experiences as compared with the subjects in the contact only group. No other differences between groups were significant. The Average Self Concept Group responded more positively in their attitudes toward professionals when exposed to the information only experience. The Low Negative Self Concept Group appeared to have responded more effectively in the contact only and contact-plus-information groups, but these differences were not significant (Duncan Multiple Range Test).

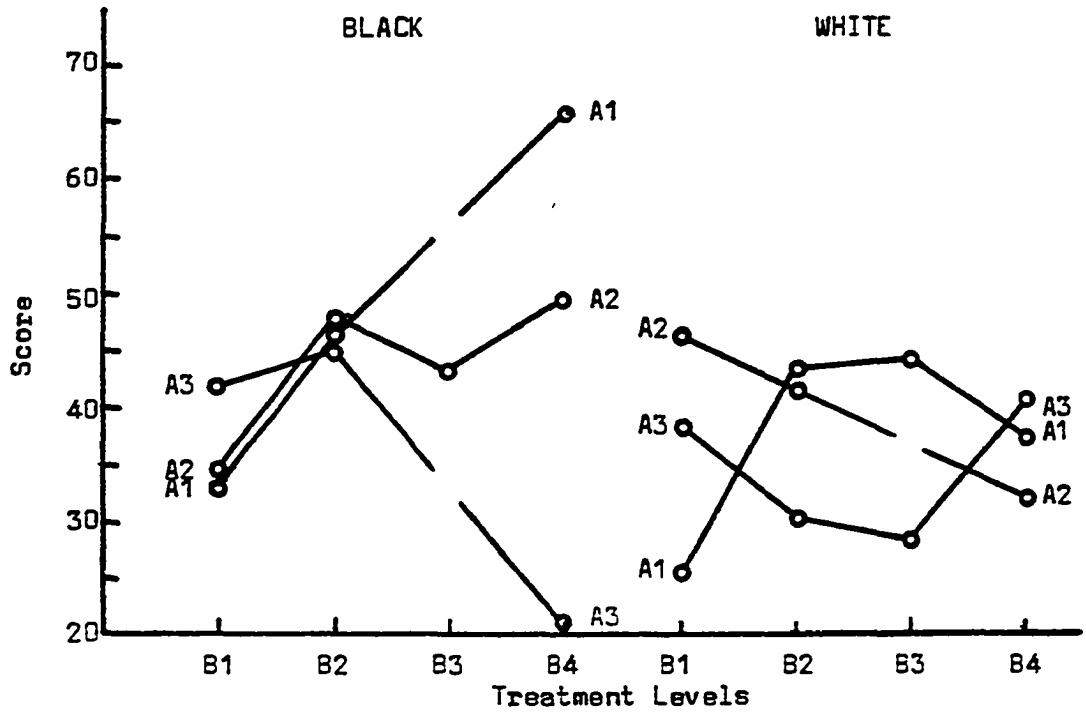
In addition, the interaction of Self Concept, Treatment Program and Race was significant ($F = 3.10$, $P < .05$) in relation to the dependent variable, Attitude Toward Professionals. This meant that the interaction of Self Concept and Treatment on attitude toward professionals was different for the races. The interaction is shown in Figure 14 and the means are reported. As tested by the Duncan Multiple Range Test, the Black subjects with the high positive self concepts had significantly more positive attitudes toward professionals in the control group when compared with subjects in the contact only and information only groups. There were no differences between the attitudes of subjects in the contact only and information only groups. There were no subjects in the contact-plus-information group.

FIGURE 13
Mean Scores for the Interaction of Self Concept and Treatment for the ATWPS: Attitude Toward Professionals
Wayne Community College



		TREATMENT				
		B1	B2	B3	B4	Mean
SELF CONCEPT	A1	35.33	50.31	54.31	54.33	48.57
	A2	39.82	48.32	38.91	45.53	43.14
	A3	46.11	46.33	39.55	42.50	44.38
	Mean	40.42	48.32	44.26	47.45	

FIGURE 14
Mean Scores for the Interaction of Self Concept, Treatment, and Race for the ATWPS: Attitude Toward Professionals
Wayne Community College



		SELF CONCEPT							
		BLACK				WHITE			
		A1	A2	A3	Mean	A1	A2	A3	Mean
TREATMENT	B1	33.33	34.33	42.33	36.66	35.83	56.00	48.00	46.61
PROGRAM	B2	47.50	47.42	46.33	47.08	53.60	52.33	40.00	48.64
	B3		38.84		38.84	54.32		38.50	46.41
	B4	65.33	49.83	19.72	44.96	48.83	42.72	50.11	47.22
	Mean	48.72	42.60	36.13		48.14	50.35	44.15	

The Black subjects with average self concepts were more positive in their attitudes toward professionals in the information only and control groups when compared to the contact only group. There were no significant differences between the attitudes of subjects in the other groups. The Black subjects with low negative self concepts were more positive in their attitudes toward professionals in the information only and contact only groups when compared with the control group. The subjects in the control group exhibited very negative attitudes toward professionals.

The White subjects with the high positive self concepts were significantly more positive in their attitudes toward professionals in the contact-plus-information and information only groups when compared with the contact only and control groups. No significant differences were found between attitudes toward professionals of subjects in the other groups. The White subjects with average self concepts were most positive in their attitudes toward professionals in the contact only group versus the control group. Other differences between groups were not significant. White subjects with low negative self concepts responded significantly more positive in their attitudes toward professionals in the control group when compared with subjects in the information only and contact-plus-information groups.

Few similarities were found when comparing the Black and White subjects in the three self concept groups. Each Black and White self concept group responded differently to each of the four levels of treatment. Interestingly, the Black and White subjects with low negative self concepts exhibited a striking pattern of responding to the Treatment

Program. That is, the Black Low Negative Self Concept Group was more positive in their attitudes toward professionals in the information only group while the White Low Negative Self Concept Group was more positive in their attitudes toward professionals in the control group.

Time was also a significant variable in reference to Attitude Toward Professionals ($F = 4.53$, $P < .01$). As tested by the Duncan Multiple Range Test, the mean for the pretest (47.54) was significantly different from the delayed posttest mean (41.92). Even though there was a difference in the negative direction from the pretest mean to the posttest mean (45.52), it was not significant. In other words, subjects evidenced an increasingly negative attitude toward professionals from pretest to posttest and from posttest to delayed posttest, but only the change from pretest to delayed posttest was significant.

Summary

In this chapter, the results of the research were reported by including measures for controlling extraneous variables, the testing of the twelve hypotheses for Wayne Community College and Western Piedmont Community College, and the presentation of some significant data for Wayne Community College using Race as a fourth variable.

The next chapter concerns itself with summary and discussion of results across the two colleges and by Race; it then relates these findings to previous research.

CHAPTER V

IMPLICATIONS OF THE FINDINGS

The basic aims of this study were to investigate the attitudes of paraprofessional trainees toward mental illness, work in community mental health, and their attitudes toward professionals in the area. Related to these aims, questions were also raised concerning the relation of self concept with attitudes, attitude change, and attitude stability over time.

In recent years, society has witnessed a profound concern for the inadequate number of professionals to serve persons needing psychological help. Many programs to train paraprofessionals in community mental health proliferated to aid in alleviating this shortage. With the growing interest in preventive psychiatry, mental health professionals have expressed increased concern about the utilization of these paraprofessional personnel. It would be useful if empirical research could provide insights into attitudes of paraprofessionals toward mental illness, their work, and professionals in the area. Questions such as the following have been asked: What type of personality do paraprofessionals have? Do they have positive or negative self concepts? Do self concepts affect their views of mental illness, their work, and professionals? What type of training experience will produce paraprofessionals who are more effective mental health workers?

Forty-eight paraprofessional trainees at Wayne Community College and forty-five paraprofessional trainees at Western Piedmont Community

College were subjects for this for this study. The data collected and the results obtained were described in the previous chapter.

Before discussing the hypotheses the experimenter would like to point out that, contrary to expectations, the control group demonstrated an attitude change on numerous items; consequently, it cannot be considered a "true" control. The experimenter believes that this may have resulted from the type of information and activities the group engaged in during the Treatment Program, and the training they received after the experimental period. The findings from the control group actually resembled those from the information group. Such findings have also been reported by other researchers studying attitudes toward mental illness (Cleland & Cochran, 1961; Hicks & Spaner, 1962).

Attitude Toward Mental Illness

The first four factors on the Opinion About Mental Illness scale will be discussed in pairs, as they cluster, Factors A and D, and Factors B and C. Factor E (Interpersonal Etiology) will be discussed alone. Cohen and Struening (1964) have pointed out the clustering of Factor A (Authoritarianism) and Factor D (Social Restrictiveness), and Factors B (Benevolence) and C (Mental Hygiene Ideology) on the Opinions About Mental Illness Scale. Granted that these factors may cluster, the subjects at Wayne Community College and Western Piedmont Community College to some extent did not cluster as anticipated. The analysis of variance table demonstrated that there were significant main effects and interactions for Factors A (Authoritarianism) and B (Benevolence) for Wayne Community College, and significant main effects and interactions for Factors D (Social Restrictiveness) and C (Mental Hygiene Ideology) for Western Piedmont Community College. Perhaps the

difference could in part be attributed to the variation in days the Treatment Program was administered at the two schools, the activities in the curricula, and/or the different racial composition of the groups at the two schools.

Factors A (Authoritarianism) and D (Social Restrictiveness)

The first hypothesis was formulated with the expectation that there would be a significant difference in attitudes toward mentally ill persons between those subjects classified in the different self concept categories.

Wylie's studies of the self concept and research of the literature on the subject (1961, 1974), hypothesized association between self concept and acceptance of others and her findings supported this relationship. Rogers (1954) in research at the University of Chicago produced clinical evidence of a positive relationship of attitudes toward self and attitudes toward others.

This research found that self concept was not significantly related to authoritarianism, a factor which stresses the inferiority of emotionally disturbed people and views coercive handling as necessary for their control, although all subjects did become significantly less authoritarian over the three testing periods at Wayne Community College; this variable was not significant at Western Piedmont Community College. This inconsistency possibly resulted from several factors related to the curricula of the two different schools. At Wayne Community College, high importance is placed on student participation in group sessions (e.g. encounter and sensitivity groups), but these are not stressed at Western Piedmont Community College. At the latter

school, a course on group processes is included in the curriculum, but little emphasis is placed on group experience. Assistant I, who was in charge of the control group at each school, engaged in a number of "group activities" with each population sample. Following these activities, she commented on the differences: "Western Piedmont Community College subjects interacted very slowly but finally became a group. Wayne Community College subjects were already a group, and interacted well almost immediately."

Social Restrictiveness (Factor D), a factor which suggests that persons believe that emotionally disturbed individuals represent a threat to their families and to society and advocate curtailment of their social functioning both during and following hospitalization, was significant at Western Piedmont Community College, but not at Wayne Community College. In this statistical analysis, information only provided treatment whereby the subjects became less socially restrictive. Gelfand and Ullman (1961) found that students became less authoritarian and less socially restrictive after psychiatric nursing training.

Four Factor Analysis of Variance Using "Race" as a Fourth Variable: Wayne Community College. The interaction of Self Concept, Treatment Program and Time was significant in the four-way analysis of variance but not in the three-way analysis of variance as mentioned previously. Therefore, these data and the discussion are engaged in somewhat cautiously.

The Average Self Concept subjects in the control group and the Low Negative Self Concept subjects in the contact group became

increasingly less authoritarian over the three testing periods. This finding supports that of Chinsky and Rappaport (1970) who stated that subjects more negative toward mental illness were likely to make the greatest change over time as did the Low Negative Self Concept Group in this study. All of the other subjects in the self concept groups increased in their attitudes on the Authoritarian dimension. This point appears to contradict some of the findings from other studies which reported people with positive self concepts as being more accepting of others (Berger, 1952; Wylie, 1961, 1974). Yet it is substantiated by Wendelman (1965) who found that persons who are authoritarian tend to be conservative and to have negative attitudes toward the mentally ill.

The contact and control group experiences were the most effective in changing the subjects' attitudes on the authoritarian dimension for all three self concept groups; information was the least effective. Cleland and Chambers (1959) found that a tour of an institution for the mentally retarded produced both positive and negative expressions of attitudes by students. Altrocchi and Eisdorfer (1961) found that nursing students who did have contact with patients during their courses did show positive attitude change. These authors also found that for people who are relatively well-informed, favorable changes in attitudes toward mental illness were not likely to result from increased information alone, but from training which also included contact with patients and the learning of therapeutic behavioral techniques. Students in community mental health programs are given a good orientation and packet of materials relative to mental illness. Therefore, they should

be relatively well informed early in the program.

Supporting some findings and contrary to those of other studies, the results from this research indicate that there were no significant differences between the self concept of Black and White subjects at Wayne Community College on the authoritarian dimension. However, Edgerton and Hollister (1973) did report that Blacks were more prejudiced toward mental illness than Whites.

In Social Restrictiveness, however, the interaction of Race and Time was significant. At Wayne Community College, Blacks became less socially restrictive over the three testing periods, while White subjects became more socially restrictive over time. In other words, the White subjects believed more than the Black subjects that emotionally disturbed individuals represent a threat to their families and to society and advocate curtailment of their social functioning both during and following hospitalization. Many factors in the socialization of both Black and White subjects could account for this behavior. Hollingshead and Redlich (1958) stated that lower status groups were likely to show greater tolerance of deviance. This factor may aid in explaining the difference in performance between the two groups since the ratio of Black subjects to White subjects in the Lower Class was 2:1. However, Dohrenwend and Chin-Shong (1967) did not find greater tolerance of deviance in low-status groups. Rather what they suggested was that lower-status groups were predisposed to greater tolerance of the kinds of deviance that both they and higher-status groups define as serious mental illness. These authors stated that the low status groups' definition as serious mental illness was narrower than that of

higher-status groups, giving the appearance of greater tolerance of deviance as seen from the vantage point of higher-status groups, including the mental health professionals.

Factors B (Benevolence) and C (Mental Hygiene Ideology)

Interaction of Self Concept and Time was significant for the factor of Benevolence, which emphasizes a kindly, paternalistic view toward emotionally disturbed individuals. At Wayne Community College, the different self concept groups responded in different ways over the three testing periods. For each self concept group, there was an increase in the benevolent attitudes at one of the testing periods. However, there was a significant decrease from posttesting period to the delayed posttesting period. The subjects in the High Positive Self Concept Group were not as amenable to being influenced as the Average Self Concept subjects and the Low Negative Self Concept subjects. Fitts (1972b) found similar results in his studies of different self concept groups. The High Positive Self Concept subjects maintained similar scores throughout the testing period. The Average Self Concept Group exhibited a behavior characteristic of latent learning, a delayed reaction of "wait and see" behavior. Significant change toward a more benevolent attitude came between the posttest and the delayed posttest. The Low Negative Self Concept Group was more amenable to immediate change, but once the influencing agent was removed, the original behavior returned. These subjects became significantly more benevolent from posttest to delayed posttest.

Interaction of Self Concept and Treatment Program was significant for Mental Health Ideology, which views mental illness as being like

any other type of illness and thus as amenable to treatment, at Western Piedmont Community College, but not at Wayne Community College. Again, all three self concept groups responded differently to the levels of treatment. Treatment levels more effective for increasing positive attitudes toward mental hygiene ideology were, in descending order: contact only, information only, contact-plus-information and control. For the Average Self Concept Group effective treatment levels were, in order, contact only, information only, control and contact-plus-information; and for the Low Negative Self Concept Group, effective treatment levels were, in descending order, information only, contact only, contact-plus-information and control.

The reasons for the three self concept groups responding differently to the four levels of treatment are probably varied. Unfortunately, accounting for these differences is beyond the scope of this study.

One basic point relative to the behavior of the subjects in reference to Factors B and C is that all subjects increased positively in some of their attitudes at some points during the research. Support for this performance has been reported by Baker and McPheeters (1975) and Kepes, Hadley, and True (1968) Baker and McPheeters found that at the end of a two year period, students in seven mental health associate degree programs had increased on Factors B and C. Kepes, Hadley and True (1968) found that over a one year period, the attitudes of their students changed in the expected direction: Lower A and D scores, higher B and C scores.

Four Factor Analysis of Variance Using "Race" as A Fourth Variable: Wayne Community College. The interaction of Treatment Program and Time was significant with the Race variable added. However, the different levels of the Treatment Program were not equally effective in increasing the benevolent attitudes of subjects over time. Contact only and contact-plus-information were the most effective when the two races were combined. However, when Race was analyzed as a variable, the Black subjects responded better to the control group experiences than to contact-plus-information experiences, while the White subjects responded better to contact-plus-information experiences than to information experiences. Many variables operating in the socialization process of the two racial groups would account for these preferences of treatment, differences which are frequently discussed by social psychologists.

Differences in preferences of treatment may have resulted from the fact that Black subjects were not as disciplined intellectually as the White subjects. Therefore, they were "turned off" by the lecture method presentation of information. Also, some "Experimenter Effect" may have operated due to the racial group to which Assistant I belonged (White American) and the racial group to which the experimenter belonged (Black American). Assistant I had charge of the control group and the experimenter had charge of the information group. Cook (1970), Pettigrew (1964), Willie, Krammer, & Brown, (1973) found that White Americans were more capable of influencing attitudes of Blacks of certain age groups than other Black Americans, and that Black students performed better on tests if the examiner were White.

The positive response of subjects to information is not in agreement with findings from several other studies (Altrocchi & Eisdorfer, 1961; Chinsky & Rappaport, 1970). Perhaps this result can partly be explained in the words of Anthony (1972); the "untested possibility remains that the information presented by the professionals is faulty and that some other kind of information would be more effective in facilitating attitude change" (p. 121). However, these findings relative to the effectiveness of information in changing attitudes do support the findings from other research. Costin and Kerr (1962) administered the OMI before and after an abnormal psychology course. The authors found that all women regardless of class rank, and those men in the upper half of their class, became less authoritarian and less socially restrictive in their attitudes. Graham (1968) gave the OMI to students in introductory and abnormal psychology courses at the start and end of a 10-week term. Scores on the Interpersonal Etiology scale rose in both classes. In a similarly designed study, Gulo and Fraser (1967) found that Social Restrictiveness scores declined.

In short, several studies have succeeded in demonstrating the effectiveness of information in changing questionnaire-measured attitudes about mental illness, and some studies have not. Certain of the results from this research are complicated and difficult to follow and to generalize from. However, attitudes themselves are still confusing to social psychologists, and research into attitudes, attitude change and attitude stability relative to community mental health is still very sparse. The field is one of enormous potential.

Factor E. Interpersonal Etiology

The variable, Time, was significant for the factor, Interpersonal Etiology, for Western Piedmont Community College, but not for Wayne Community College. This factor reflects the extent of belief that emotional disturbance arises from interpersonal experiences, particularly those involving love and attention during childhood. Factor E appears to be more cognitive than attitudinal as discovered by Cohen and Struening (1964). The subjects became more and more convinced of their belief as to the etiology of mental illness over the three testing periods. These findings support the studies of Baker and McPheeters (1975) who found that students in community mental health programs increased their scores on this factor of the opinions about mental illness scale with the control group, students in other areas, did not.

Four Factor Analysis of Variance Using "Race" as A Fourth Variable: Wayne Community College. The interaction of Self Concept, Treatment Program, and Race was significant for Factor E, Interpersonal Etiology. Again, different self concept groups of both Black and White subjects respond positively to different levels of the Treatment Program. For this dependent variable, the Black and White subjects with high positive self concepts were more effectively influenced by contact only, information only and control group experiences. However, there the similarities ended. The other two self concept groups varied in their responses according to race.

The interaction of Self Concept, Race, and Time indicated that the three self concept groups of Black and White subjects still responded

differently. However, there were some vague similarities between the response patterns of the following groups which were very interesting. The Black Average Self Concept Group and the White Average Self Concept Group were similar, but on different levels of the dependent variable, Interpersonal Etiology.

Attitude Toward Work

Variables pertaining to attitude toward work were not significant for either Wayne Community College or Western Piedmont Community College.

Four Factor Analysis of Variance Using "Race" as A Fourth Variable: Wayne Community College. Despite the lack of significance in the three way analysis of variance, the four way analysis showed the interaction of Race and Time to be significant in relation to attitude toward work.

The linear performance of the Black subjects over the three testing periods may well have resulted from the increased sensitivity and feelings of "togetherness" that Blacks have developed during the sixties and early part of the seventies. This "feeling" may be somewhat comparable to that of a budding counselor or psychologist who feels that he can go out and "save the world" (Hall, Cross, & Freedle, 1972). A second reason may have been that the training program was so different from their previous experiences that it enhanced their feelings of self worth (Altrocchi & Eisdorfer, 1961; Bovard, 1958; Holzberg & Gewirtz, 1963; Jones, 1972).

The White subjects, in contrast to the Black subjects, appeared to have experienced a measure of disenchantment with the community mental health program from the posttest to delayed posttesting. Some comments were made to the assistants and the experimenter by several subjects

during the posttesting period such as "We thought that we were a select group, but everybody is in this program!" "It (community mental health program) is not what I thought it was going to be." From the stated job experiences of some of the White subjects, it is understandable why many of them may have been disappointed with the beginning of the training program. This is a time when the basic courses are taught, and for many subjects, these studies may have seemed repetitious or simplistic, and for many subjects the frustration of starting over again in a career may have been reflected in their responses (Cowen, 1967).

The interaction of the Treatment Program, Race, and Time demonstrated that contact and the control group experiences were more positively effective for the Black subjects than for the White subjects. The White subjects responded in a similar manner to all levels of the Treatment Program with the exception of Level II, information. At the delayed posttesting period, the subjects exposed to this level of the Treatment Program had more negative attitudes toward work than the subjects for any other level of the Treatment Program.

By and large, the Black subjects followed their usual pattern of responding favorably to contact and control group experiences, but this did not hold true for the White subjects over time. The Treatments which provided information and contact-plus-information were shown at the posttest to have been effective in influencing more positive attitudes toward work during the delayed posttest; and control group experiences were as usual, more negative for Whites. However, after the eight week period, the delayed posttesting indicated that information experiences

had resulted in White subjects having the most negative attitudes toward work.

The information presented to the subjects on this treatment level was a positive perspective in reference to the contributions that paraprofessionals are making in the area of community mental health, a description of what they, the subjects, would be expected to do when they became mental health workers. This type of information appeared to have generated enthusiasm in the subjects. During the eight week period from posttest to delayed posttest, various experiences, in the program or elsewhere, may have caused the student to view the work situation from a more negative perspective. On the dependent variable, Attitude Toward Work, the Black subjects responded more positively than the White subjects on all treatment levels. Some of the reasons previously mentioned in reference to the level of expectation for each racial group and their previous job experiences may well account for this pattern of behavior (Cowen, 1967; Jones, 1972, Wertheimer, 1970).

Attitude Toward Professionals

The Treatment Program variable was significant for Western Piedmont Community College, but not for Wayne Community College.

At Western Piedmont Community College the control group experiences proved most effective for increasing positive attitudes toward professionals. In decreasing order of effectiveness, the other treatment levels of contact only, contact-plus-information and information only were significantly different from the control group. The subjects may have responded more favorably to the control group experiences because of the variety and interest of the experiences and the informality of

the group setting in the control group. That is, the subjects were seated on pillows on the floor, a situation quite in contrast to the usually formal and structured atmosphere at Western Piedmont Community College, where customarily a wide psychological distance is maintained between faculty and students.

Subjects at both Wayne and Western Piedmont Community Colleges became increasingly negative in their attitudes toward professionals over the three testing periods. Only one study in the literature indirectly dealt with a similar aspect of paraprofessionals' behavior, the Minneapolis New Careers Program (1969). This program did seek to ascertain whether paraprofessionals became "contaminated" by professionalization. Their findings indicated that as the paraprofessionals moved toward "professional orientation," and became more familiar with professional performance and practice, they developed more doubts and questions about professional practices and became strengthened in their allegiance to the lay community, its strengths, and the processes of mental health through community intervention. In effect, the paraprofessionals during their training period came to reject the professionals as those who were solely able to provide solutions to the problems of disturbed poor people.

In reflecting on the findings of the Minneapolis New Career Program (1969) and her own study, the experimenter offers another suggestion or hypothesis to explain why the paraprofessional subjects grew increasingly negative in their attitudes toward professionals over the three testing periods. Lay people attribute a certain omnipotence to professionals in the medical and health fields, mental as well as physical.

They usually stand in awe of the "professional mystique," as True (1970) remarked. But as these paraprofessionals learn more about the mental health profession and the professional, they begin to realize that the "halo" that was once pure and bright now appears a little tarnished, that mental health professionals are people with special skills, but not ones who can work magical cures or who are personally without blemish. A "professional mystique" which once implied that "only professionals can know and accomplish such astounding results" no longer seems as valid as it did when they knew less about the mental health profession and its professionals.

Four Factor Analysis of Variance Using "Race" as A Fourth Variable: Wayne Community College. On the four way analysis of variance with Race as the fourth variable, there was significance at Wayne Community College in the interaction of Self Concept, Treatment Program, and Race with the dependent variable, attitude toward professionals. Both Black and White subjects exposed to the information and contact experiences responded more positively in their attitudes toward professionals. Consistently following a previously reported pattern, Black subjects with high positive self concepts and average self concepts made more effective changes in the control group, while White subjects with high positive self concepts and average self concepts made more effective changes in the information group. Very interestingly, however, the Black and White subjects with low negative self concepts responded along racial lines but to opposite treatments from their previous patterns; that is, Black subjects responding positively to

contact only and control treatment, and White subjects responding to information and contact-plus-information treatment. Black subjects now exhibited more positive attitudes toward professionals in the information group, while the control group experiences affected them very negatively. The White subjects with low negative self concepts exhibited more positive attitudes toward professionals in the control group, and the information only experiences were negative for them. In explanation, these subjects may have been reacting not to the level of treatment itself, but to the racial background of the leaders, as the control group was conducted by a White American, and the information group by the experimenter, a Black American. The need to identify with a like role model is very strong in subjects with negative self concepts as found by Fitts (1972a), Jones (1972), and Willie, et al., (1973).

Although attitude toward professionals had not been significant at Wayne Community College on the three way analysis of variance, in the four way analysis the main effects and interactions of Self Concept and Treatment Program were significant on the dependent variable, attitude toward professionals. The three self concept groups again responded differently to the four levels of the Treatment Program, although many subjects made positive responses to the information experiences. Specifically, in a comparison of the effectiveness of the different treatment levels for increasing positive attitudes toward professionals, the self concept groups responded in the following manner: the High Positive Self Concept subjects were most influenced by information experiences, second by contact-plus-information experiences,

and third by control group experiences. The Average Self Concept subjects were most influenced by information experiences. The Low Negative Self Concept subjects responded in the same way to all experiences; although this group appeared to respond more effectively to the information only experiences, the differences were not significant. The response patterns for the self concept groups were once again complex and difficult to explain. No findings from previous research studies contribute any suggestions for explaining these varied effects. The experimenter suggests, however, that the giving of accurate information through lectures about professionals and their contribution to community mental health does prove useful in training paraprofessionals.

The main effect of the variable, Time, was significant in the four factor analysis of variance which included Race in reference to attitude toward professionals. The subjects had increasingly negative attitudes toward professionals over the three time periods. Possible reasons for these results have already been stated. Furthermore, it is quite possible that those subjects who were most positive in their responses to the control group did not perceive the leader of that group, Assistant I, as a mental health professional, but as a person more like one of themselves. The contrast between this experience and their later contacts with professionals may have had a negative influence on their attitude toward those professionals.

Summary

Attitude studies related to mental illness and other phases of community mental health are still in their infancy and, as pointed out

in the literature, the findings from research studies are very ambiguous. The experimenter had hoped to clarify some specific points regarding attitudes through this study. Although the data presented warrant some generalizations, the researcher does not have definitive positions on any of the hypotheses raised. Null hypotheses were retained and rejected in a most varied manner, and the multi-directional patterns of significance left the experimenter with large numbers of unresolved questions. Despite this being true, some few conclusions can be suggested.

This chapter discussed the most salient findings of the study. Even though there were several unanticipated results, and some other expectations did not materialize, in Chapter VI a few generalizations will be stated briefly, and some possible implications for future research will be mentioned.

CHAPTER VI

SUMMARY AND CONCLUSIONS

The problem of this research was to assess the attitudes of paraprofessionals in community mental health toward mental illness, their work, and professionals; to find if these attitudes related to the self concept; to attempt to cause a more positive directional change in these attitudes; and to determine how stable any obtained changes might be over an eight week period.

Summary

The study involved the exploration of twelve hypotheses. The first was concerned with the attitude toward mental illness as related to the Self Concept; the second dealt with the significance of a Treatment Program to change attitudes; the third was concerned with the interaction of the Self Concept and the Treatment Program; and the fourth dealt with the stability of attitudes over time. The remaining eight were restated to refer to the dependent variables of attitude toward work and attitude toward professionals with the same independent variables.

Forty-eight paraprofessional trainees from Wayne Community College and forty-five paraprofessional trainees from Western Piedmont Community College were the subjects of this study. Treatment for attitude change consisted of four treatment groups: contact only, information only, contact-plus-information, and control. A recognized measure of Self Concept was administered and three levels of Self Concept were employed in the pretest, posttest and the delayed posttest to measure attitudes

toward work and professionals as they might be affected by that treatment.

Prior studies have demonstrated positive attitude change toward mental patients in college and senior high school students. This study showed similar changes for paraprofessional trainees, although the extent and direction of change varied with the Self Concept and the Treatment level. Other findings of this study come from an empirical assessment of the attitudes of paraprofessional trainees toward their work and professionals at the beginning of their training period, the influence of effective contact and information experiences on the attitudes of subjects with certain types of Self Concepts, and differences between Black and White subjects in attitudes and effective Treatment levels.

Some of the results of this investigation which did not agree with previous research studies were: (1) contact-plus-information experiences did not consistently prove to be the most effective treatment as previous research had lead this experimenter to believe; (2) there was not a linear relationship between high, average or low self concepts and changed attitudes toward work and professionals, or attitudes toward the mentally ill, with the one exception of Black subjects on the dimension of attitudes toward work; (e) there were no differences in the Self Concept of Black and White subjects as they related to attitudes toward mental illness, work, and professionals; and (4) Blacks were not more prejudiced toward mentally ill persons than Whites.

The assumption that attitudes are multi-dimensional is built into the five dimensions of the scale Opinions About Mental Illness and was adopted as a primary concept on which this study was designed. This multi-dimensional construct proved useful in analyzing and explaining

contradictions in the findings. Treatment by contact, information, contact-plus-information, and control group experiences differed widely on the attitude dimensions in relation to the Self Concept and Race variables.

An increase in favorable attitudes toward mental patients replicated the findings of such studies as those of Schiebe (1965) and Turner et al. (1967) working in state hospital projects.

Conclusions

Even though broad generalizations are not warranted, the experimenter believes that the following major findings were clearly substantiated by the data from the present research.

1. There is a relationship between the Self Concept of subjects and methods of treatment used to change attitudes toward mental illness, work, and professionals:
    - 1a. The effectiveness of different types of treatment was contingent on the Self Concept.
    - 1b. Low Negative and Average Self Concept persons were more amenable to positive change in attitudes toward mental illness than High Positive Self Concept persons both during the treatment and in the eight weeks period following.
    - 1c. Contact and information experiences were the more effective methods of treatment for some groups for changing attitudes in a positive direction.

2. All self concept groups decreased on the Authoritarianism and Social Restrictiveness dimensions, and increased on the Benevolence and Mental Hygiene Ideology dimensions at some point in time over the three testing periods.

    2a. However, some types of Treatment caused some groups to become more authoritarian at specific testing periods.

3. All self concept groups increased on the Interpersonal Etiology factor at some point in time.

4. All subjects became increasingly more negative in their attitudes toward professionals over the three testing periods.

5. Attitude changes in the control group may have resulted from several unmeasured variables: the group interaction experiences in which the subjects spent their time, their positive response to a humanistic environment, a "Hawthorne effect" resulting from reinforcement of training as participants in an important experiment involving innovations in community mental health training programs, or other unknown causes.

6. The durability of attitude change, at least for a period of eight weeks, was demonstrated with some self concept groups exposed to certain levels of treatment. Unanticipated additional changes in a positive direction at the delayed posttest time might be interpreted as a delayed response resulting from cognitive restructuring initiated during the Treatment period. On the other hand, increased positive attitudes could have

been fostered by the educational program which followed the experiment, and in this case could not be attributed to the experimental treatment groups.

7. It was possible to change attitudes in a 10 hour time period as measured by the instruments used in this research study, but the changes were not unidirectional.

8. Blacks were not more authoritarian than Whites and they were not more negative toward mental illness.

9. The Self Concept of Black subjects was not more negative than those of White subjects in relation to attitudes toward mental illness, work and professionals.

10. Black subjects showed increasingly positive attitudes toward work in community mental health, a linear relationship over time, than White subjects. White subjects showed a decrease in positive attitudes toward mental health work over time.

11. Different types of Treatment appeared to be more effective for Black and White subjects in positively changing their attitudes toward mental illness, work and professionals in community mental health.

12. With Low Negative Self Concept subjects, the type of Treatment decreased in importance when the factor of Race was introduced.

Finally, some seemingly erratic patterns of attitude change were not anticipated by the experimenter, and several apparent changes appeared to be influenced by uncontrolled or adjunct behaviors, such as

aspects of the school curricula outside of the experimenter's control, social learning not immediately connected with either school or program, and the maturation of subjects. This study was not designed to take these variables into account.

Implication For Future Research

While generalizations from this study are specific to the particular method and subjects used, several areas of research appear worthy of investigation.

A. The interrelationships of attitudes, and of attitudinal dimensions and behavior

B. The effect of different types of controlled contact on attitudinal dimensions

C. Major factors that influence the stability of attitudes.

D. The comparison of time necessary for attitude change and the stability of the changed attitudes related to the level of cognitive functioning

E. The effectiveness of different types of information and methods of presentation on attitude change and attitude stability.

F. How to facilitate a positive change in attitudes and the Self Concept within a short length of time, and how to keep these changes stable

G. As the self concept is indeed a significant variable in rehabilitation, as it is in mental health and other enterprises where the goal is the betterment of man, more empirical research needs to be done on activities effective for changing self concept in a positive direction.

H. Components of the negative attitudes toward professionals which this study revealed should be analyzed and studied empirically. What kinds of interactions between professionals and paraprofessionals, and which professional characteristics or attitudes lead to negative or positive relationship between the two groups?

These recommendations for future research are made with the expectation that they would report and provide important new information useful for providing more effective services in the mental health field.

In retrospect, the experimenter concludes that the training of paraprofessionals for community mental health services is and must continue to be multi-dimensional and broadly varied in approach if it is to be effective and facilitative. Persons of widely differing backgrounds and varied self concept levels will respond differently. Hence an optimal program must combine information and contact with mentally ill persons. At least part of the learning experiences should be conducted in friendly, warm, facilitative groups such as was provided by the control group, where paraprofessionals felt themselves to be accepted as persons who have valuable contributions to make to mental health services. Furthermore, it is probably very valuable to have teachers who represent different racial groups and some who are not perceived by the students as distant or superior in their professional attitudes and attainments. Perhaps this study has demonstrated again that human beings are enormously different from one to another, and that no oversimplified or doctrinaire approach is likely to reach them all; rather a multivaried program which takes human interaction into account is

likely to be most facilitative of personal growth in self concept, positive attitudes toward mental illness, work and professionals, and increasing personal effectiveness through a lifetime career in service in the community mental health arena.

Assessment of attitudes toward mental illness, work in community mental health, toward professionals, and possible methods for causing a positive change in attitudes of paraprofessionals like those in this study would seem to be particularly important due to the shortage of personnel in the helping professions. People similar to the subjects used in this investigation have a unique role, and they are likely to become key caretaking individuals or leaders in the community mental health 'revolution' of today and tomorrow.

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A P P E N D I X E S

APPENDIX A

Raw Data

TABLE A-1
Pilot Study
RAW DATA

SUBJECT	SELF CONCEPT*	RACE*	SELF CONCEPT	PRETEST - WORK*	PRETEST - PROF*	PRETEST - MIA	PRETEST - MIB	PRETEST - MIC	PRETEST - MID	PRETEST - MIE	POSTTEST - WORK	POSTTEST - PROF	POSTTEST - MIA	POSTTEST - MIB	POSTTEST - MIC	POSTTEST - MID	POSTTEST - MIE
001	2	0	27	48	19	32	51	36	19	21	52	24	28	49	36	24	23
002	2	0	27	50	15	24	49	35	12	20	46	13	26	46	32	18	19
003	1	0	5	41	26	30	41	29	25	15	53	27	27	39	22	28	19
004	2	0	16	41	28	21	42	30	19	15	54	27	19	40	31	17	13
005	1	0	9	48	23	28	55	30	17	14	51	18	29	49	31	20	14
006	2	0	12	41	23	24	46	20	23	23	44	25	30	43	28	22	19
007	1	0	6	55	17	23	46	25	25	15	53	23	28	55	25	26	18
008	2	0	29	49	19	13	55	36	16	11	46	23	10	60	36	16	8
009	1	0	5	40	14	26	55	32	25	25	53	19	20	55	35	20	25
010	2	0	20	34	11	21	52	29	22	10	43	18	19	52	25	18	10
011	1	0	4	51	13	24	51	32	18	16	47	11	23	55	35	15	15
012	2	0	10	51	27	26	58	32	19	21	50	27	31	55	28	17	21
013	1	0	7	44	15	24	58	25	21	18	43	17	22	49	28	25	21
014	2	0	24	51	20	20	60	32	18	11	48	17	17	51	38	16	19
015	2	0	35	43	25	31	47	31	18	26	51	30	23	52	30	19	10
016	1	0	7	49	21	24	57	41	13	17	52	30	25	53	39	10	18
017	2	0	19	53	19	20	60	31	18	14	60	24	16	56	35	15	21
018	1	0	9	42	9	19	55	34	17	8	49	12	17	53	37	22	14
019	2	0	13	50	9	10	55	35	11	16	49	15	14	57	37	14	20
020	1	0	0	47	17	22	60	43	11	11	54	22	2	58	42	1	3
021	2	0	24	31	10	23	41	33	17	14	39	13	30	43	34	22	16
022	1	0	5	45	21	27	52	26	25	15	51	27	21	51	26	30	18
023	2	0	34	38	10	28	54	32	21	19	39	11	28	46	31	24	20
024	2	0	20	36	17	24	59	40	12	9	43	26	20	60	44	9	9
025	1	0	8	46	27	19	65	32	18	15	44	25	28	64	38	18	13
026	1	0	6	48	20	18	55	35	13	13	48	20	18	49	36	17	18
027	2	0	16	55	18	14	60	25	22	11	53	15	12	60	38	16	16

* SELF CONCEPT: 1 = POSITIVE
2 = NEGATIVE
* RACE 0 = BLACK
1 = WHITE
* MI = MENTAL ILLNESS
* PROF = PROFESSIONAL

Table A-2
Raw Data - Level I Contact
Wayne Community College

SUBJECT	TREATMENT LEVEL	SEX	AGE	RACE*	SELF CONCEPT	PRETEST - WORK	PRETEST - PROF	PRETEST - MIA	PRETEST - MIB	PRETEST - MIC	PRETEST - MID	PRETEST - MIE	POSTTEST - WORK	POSTTEST - PROF	POSTTEST - MIA	POSTTEST - MIB	POSTTEST - MIC	POSTTEST - MID	POSTTEST - MIE	DELAYED POST WORK	DELAYED POST PROF	DELAYED POST MIA	DELAYED POST MIB	DELAYED POST MIC	DELAYED POST MID	DELAYED POST MIE
043	1	1	19	1	1	48	45	27	55	36	15	12	58	48	23	48	30	19	13	54	53	25	52	30	17	15
044	1	1	23	0	13	52	36	32	47	36	21	18	55	24	30	51	30	20	14	58	23	31	52	32	20	15
045	1	1	24	0	16	45	35	23	56	32	20	18	57	55	21	62	32	18	21	51	41	18	63	35	10	10
046	1	1	18	1	11	54	67	21	49	35	9	12	50	52	24	52	38	17	15	47	49	20	55	40	14	12
047	1	1	20	1	28	45	45	27	50	26	18	18	43	45	29	45	22	12	19	51	32	22	52	29	17	17
048	1	1	53	1	1	53	33	33	30	47	28	16	53	36	32	47	32	27	20	45	22	31	50	31	29	23
049	1	1	20	0	7	48	46	31	49	32	18	22	56	21	30	50	30	21	22	56	23	26	45	30	18	15
050	1	1	19	1	3	47	45	23	48	25	25	21	47	45	19	52	29	20	20	40	22	23	52	21	28	20
051	1	1	36	1	20	54	69	20	66	46	11	26	57	49	10	66	45	1	31	50	48	13	60	46	11	20
052	1	1	21	0	4	39	37	31	52	35	26	18	47	32	15	60	37	18	26	47	31	43	58	35	17	26
053	1	0	18	0	20	15	44	32	43	33	17	12	52	40	28	54	34	13	17	53	43	28	47	29	9	17
054	1	0	41	1	3	48	13	14	53	34	20	26	48	51	19	56	29	16	26	48	17	18	53	34	16	27

* SEX: 0 = MALE
1 = FEMALE
RACE: 0 = BLACK
1 = WHITE

Table A-3
Raw Data - Level 2 Information
Wayne Community College

SUBJECT	TREATMENT LEVEL	SEX	AGE	RACE	SELF CONCEPT	PRETEST - WORK	PRETEST - PROF	PRETEST - MIA	PRETEST - MIB	PRETEST - MIC	PRETEST - MID	PRETEST - MIE	POSTTEST - WORK	POSTTEST - PROF	POSTTEST - MIA	POSTTEST - MIB	POSTTEST - MIC	POSTTEST - MID	POSTTEST - MIE	DELAYED POST WORK	DELAYED POST PROF	DELAYED POST MIA	DELAYED POST MIB	DELAYED POST MIC	DELAYED POST MID	DELAYED POST MIE
030	2	0	39	1	9	52	62	23	54	36	16	17	54	41	23	47	26	21	16	45	44	15	51	30	20	15
031	2	0	41	0	8	48	46	22	54	38	9	14	57	49	25	49	31	18	15	56	44	24	53	32	16	23
032	2	1	19	0	30	49	48	32	44	28	22	19	39	61	31	44	28	22	19	56	22	34	42	27	22	21
033	2	1	17	0	12	49	41	38	42	27	33	22	52	53	40	42	31	31	21	55	29	38	52	32	40	29
034	2	1	21	0	12	54	41	30	44	26	22	8	44	48	31	42	27	27	16	45	57	22	49	22	16	11
035	2	1	18	1	0	36	61	18	56	32	15	21	42	59	18	56	33	18	23	38	58	17	49	32	21	32
036	2	1	36	0	1	42	45	34	53	34	12	19	45	53	23	49	34	10	16	44	39	26	53	36	10	73
037	2	1	33	0	11	50	48	29	49	35	16	15	55	57	20	60	23	20	12							
038	2	1	25	0	20	36	41	28	44	25	25	13	40	53	31	46	27	26	11	48	53	31	46	27	26	11
039	2	1	47	0	14	55	45	25	54	35	17	14	25	34	20	60	36	19	13	60	62	17	58	36	28	14
040	2	1	42	1	0	55	47	20	51	25	18	12	55	43	19	59	28	20	9	55	40					
041	2	1	22	0	3	41	40	29	50	19	19	7	49	51	18	45	29	21	19	53	49	22	51	35	21	17

* SEX: 0 = MALE
1 = FEMALE
RACE: 0 = BLACK
1 = WHITE

Table A-4
Raw Data - Level 3 Contact - Plus Information
Wayne Community College

SUBJECT	TREATMENT LEVEL	SEX*	AGE	RACE*	SELF CONCEPT	PRETEST - WORK	PRETEST - PROF	PRETEST - MIA	PRETEST - MIB	PRETEST - MIC	PRETEST - MID	PRETEST - MIE	POSTTEST - WORK	POSTTEST - PROF	POSTTEST - MIA	POSTTEST - MIB	POSTTEST - MIC	POSTTEST - MID	POSTTEST - MIE	DELAYED POST WORK	DELAYED POST PROF	DELAYED POST MIA	DELAYED POST MIB	DELAYED POST MIC	DELAYED POST MID	DELAYED POST MIE
057	3	0	50	1	1	50	64	22	57	32	25	13	51	66	18	57	31	16	19	58	61	16	62	35	10	14
058	3	0	18	1	1	47	46	33	46	30	21	18	47	44	34	48	27	31	13	54	55	30	45	25	28	18
059	3	0	31	0	8	45	28	28	48	34	20	13	51	29	24	46	33	21	14	38	20	26	54	27	15	14
060	3	1	18	0	11	45	53	26	56	30	14	5	47	54	19	53	42	6	5	40	55	23	57	42	2	15
061	3	1	18	1	25	52	37	22	54	27	23	19	40	39	20	66	33	22	14	47	45	22	61	34	22	13
062	3	1	21	1	2	52	50	15	56	32	13	9	55	56	11	59	40	9	9	45	37	15	56	23	13	8
063	3	1	20	0	30	48	38	38	54	36	24	24	33	24	37	59	34	19	17	47	32	35	54	31	21	21
064	3	1	20	1	3	50	55	12	56	26	25	8	40	53	15	56	25	21	10	48	59	20	57	26	25	11
065	3	1	28	0	30	49	53	24	55	36	17	24	47	33	26	51	38	18	17	53	53	21	69	38	13	19
066	3	1	20	1	5	53	61	21	40	30	21	14	60	55	22	49	29	21	19	55	52	20	49	32	23	19
067	3	0	19	1	40	48	62	28	56	40	9	14	51	38	35	56	28	19	14	29	10	37	52	37	12	11
068	3	0	20	0	16	46	54	22	49	27	17	12	51	33	29	46	31	21	17	49	24	33	56	35	10	8

* SEX: 0 = MALE
1 = FEMALE
* RACE: 0 = BLACK
1 = WHITE

Table A-5
Raw Data - Level 4 - Control
Wayne Community College

SUBJECT	TREATMENT LEVEL	SEX*	AGE	RACE*	SELF CONCEPT	PRETEST - WORK	PRETEST - PROF	PRETEST - MIA	PRETEST - MIB	PRETEST - MIC	PRETEST - MID	PRETEST - MIE	POSTTEST - WORK	POSTTEST - PROF	POSTTEST - MIA	POSTTEST - MIB	POSTTEST - MIC	POSTTEST - MID	POSTTEST - MIE	DELAYED POST WORK	DELAYED POST PROF	DELAYED POST MIA	DELAYED POST MIB	DELAYED POST MIC	DELAYED POST MID	DELAYED POST MIE
071	4	1	35	1	24	57	59	20	49	33	20	13	49	64	22	50	33	21	17	50	59	17	49	34	12	15
072	4	1	22	1	35	47	45	27	36	33	21	16	49	35	29	46	35	50	19	42	26	31	37	31	23	14
073	4	0	30	0	25	50	12	34	40	42	24	23	52	20	33	53	44	22	21	55	27	29	48	42	23	26
074	4	1	18	1	4	52	64	26	53	28	14	15	46	44	31	45	25	20	17	54	66	22	39	27	15	18
075	4	0	32	0	7	60	60	37	68	32	17	10	60	45	22	58	33	12	10	60	43	19	63	36	25	6
076	4	1	18	1	18	55	52	12	54	25	17	14	55	52	12	54	25	17	14	60	59	12	54	25	17	14
077	4	1	20	1	9	45	36	29	51	32	17	17	45	38	29	51	32	17	17	48	49	36	58	35	24	19
078	4	1	29	0	17	51	45	33	50	31	17	18	55	60	28	50	31	18	10	55	46	26	52	28	19	12
079	4	1	18	1	4	50	50	39	43	31	26	21	61	31	32	45	37	20	21	48	38	34	49	38	27	22
080	4	1	18	0	1	51	66	25	62	37	21	14	55	64	26	62	38	15	15	60	66	20	62	39	11	8
081	4	1	18	1	11	54	41	35	44	29	27	17	49	40	29	45	30	29	17	46	37	27	51	34	27	14
082	4	1	31	0	9	48	53	25	43	31	22	11	38	43	25	41	21	28	19	60	47	17	44	28	28	13

* SEX: 0 = MALE
1 = FEMALE
* RACE: 0 = BLACK
1 = WHITE

Table A-6
Raw Data - Level 1 - Contact
Western Piedmont Community College

SUBJECT	TREATMENT LEVEL	SEX*	AGE	RACE*	SELF CONCEPT	PRETEST - WORK	PRETEST - PROF	PRETEST - MIA	PRETEST - MIB	PRETEST - MIC	PRETEST - MID	PRETEST - MIE	POSTTEST - WORK	POSTTEST - PROF	POSTTEST - MIA	POSTTEST - MIB	POSTTEST - MIC	POSTTEST - MID	POSTTEST - MIE	DELAYED POST WORK	DELAYED POST PROF	DELAYED POST MIA	DELAYED POST MIB	DELAYED POST MIC	DELAYED POST MID	DELAYED POST MIE
008	1	1	18	1	31	50	41	24	36	25	23	12	53	50	23	31	28	22	15	52	48	20	37	32	119	13
009	1	1	19	1	5	55	55	16	59	42	12	14	50	57	17	61	39	18	20	44	32	20	51	37	16	20
090	1	1	20	0	31	42	33	33	46	22	25	21	44	28	33	46	29	31	19	41	28	35	38	28	27	19
091	1	1	20	1	5	60	59	32	50	29	21	24	45	49	31	50	29	21	24	48	28	30	51	31	20	35
092	1	1	18	1	22	43	29	28	47	27	26	18	51	41	25	47	27	25	20	54	31	22	47	33	22	19
093	1	1	23	0	25	57	39	25	41	27	15	21	52	39	25	42	27	14	21	51	49	16	41	29	10	8
094	1	0	21	1	5	43	56	16	57	31	10	15	38	61	13	46	28	6	8	43	63	13	52	32	7	20
095	1	0	40	1	9	41	34	33	64	41	25	13	49	37	33	65	41	25	13	48	14	23	59	34	19	23
096	1	0	24	1	10	50	43	19	57	37	13	25	49	34	17	59	37	11	22	51	36	10	52	32	14	22
097	1	1	48	1	5	54	61	16	62	35	10	17	51	47	14	61	36	18	16	51	22	13	61	35	17	17
098	1	1	18	1	20	20	14	14	51	23	23	15	50	45	14	50	22	24	15	47	38	23	50	22	22	23

* SEX: 0 = MALE
1 = FEMALE
RACE: 0 = BLACK
1 = WHITE

Table A-7
Raw Data - Level 2
Western Piedmont Community College

SUBJECT	TREATMENT LEVEL	SEX*	AGE	RACE*	SELF CONCEPT	PRETEST - WORK	PRETEST - PROF	PRETEST - MIA	PRETEST - MIB	PRETEST - MIC	PRETEST - MID	PRETEST - MIE	POSTTEST - WORK	POSTTEST - PROF	POSTTEST - MIA	POSTTEST - MIB	POSTTEST - MIC	POSTTEST - MID	POSTTEST - MIE	DELAYED POST WORK	DELAYED POST PROF	DELAYED POST MIA	DELAYED POST MIB	DELAYED POST MIC	DELAYED POST MID	DELAYED POST MIE
103	2	1	19	1	21	56	66	27	52	34	18	21	53	39	30	54	39	13	21	53	39	32	56	42	12	21
104	2	0	24	1	43	45	56	18	50	33	16	21	47	56	15	54	38	14	20	45	20	13	56	35	10	20
105	2	1	19	0	25	47	21	39	39	21	23	26	51	27	33	42	36	24	25	45	40	30	49	33	27	22
106	2	0	23	1	15	49	55	30	48	34	16	15	53	47	24	48	34	15	21	45	42	23	46	33	18	26
107	2	1	18	1	3	56	38	29	47	31	27	21	50	46	31	59	31	23	26	45	44	32	44	31	26	23
108	2	1	32	0	13	47	43	32	36	21	33	15	25	33	20	37	27	16	11	25	37	41	40	35	17	24
109	2	0	30	1	6	39	60	9	60	29	20	8	39	60	18	56	36	15	11	42	12	18	57	34	16	11
110	2	0	25	1	32	48	28	15	59	36	18	16	47	20	15	57	30	19	24	45	25	19	61	39	23	18
111	2	1	24	0	40	52	34	23	49	36	14	7	45	29	25	55	38	17	1	47	35	17	57	34	8	13
112	2	1	31	1	7	42	39	29	63	35	7	21	43	19	28	60	42	3	23	41	25	26	57	37	4	19
113	2	0	19	1	6	49	46	17	53	30	17	9	41	34	24	54	33	10	4	42	35	17	50	32	19	12

* SEX: 0 = MALE
1 = FEMALE
RACE: 0 = BLACK
1 = WHITE

Table A-8
Raw Data - Level 3 - Contact - Plus Information
Western Piedmont Community College

SUBJECT	TREATMENT LEVEL	SEX*	AGE	RACE*	SELF CONCEPT	PRETEST - WORK	PRETEST - PROF	PRETEST - MIA	PRETEST - MIB	PRETEST - MIC	PRETEST - MID	PRETEST - MIE	POSTTEST - WORK	POSTTEST - PROF	POSTTEST - MIA	POSTTEST - MIB	POSTTEST - MIC	POSTTEST - MID	POSTTEST - MIE	DELAYED POST WORK	DELAYED POST PROF	DELAYED POST MIA	DELAYED POST MIB	DELAYED POST MIC	DELAYED POST MID	DELAYED POST MIE
118	3	0	33	1	42	41	46	25	51	29	29	10	34	50	15	49	36	7	16	43	58	15	48	34	19	20
119	3	0	36	1	34	39	35	40	47	31	35	27	40	8	36	45	31	32	24	25	13	37	41	30	34	24
120	3	1	28	1	8	60	57	19	38	29	16	19	63	43	17	51	35	13	23	63	58	20	49	31	14	23
121	3	0	26	1	18	49	38	17	49	29	10	27	46	36	16	51	27	15	17	51	32	19	46	30	18	17
122	3	0	23	1	38	42	40	33	42	22	26	23	40	38	34	40	30	23	24	48	39	42	31	34	28	27
123	3	0	27	1	4	51	40	35	55	28	30	11	42	40	37	58	31	24	18	40	40	39	61	34	36	20
124	3	0	20	0	25	47	44	20	46	30	16	17	53	30	18	58	24	14	19	57	25	21	59	33	16	20
125	3	1	18	1	18	50	53	26	56	35	10	14	44	30	28	22	29	15	17	52	51	28	55	39	10	18
126	3	0	36	1	19	49	53	24	49	32	18	25	49	23	16	49	32	18	25	46	31	18	56	33	16	22
127	3	1	28	1	5	50	50	15	45	31	11	14	49	44	12	48	37	11	19	39	35	15	45	33	14	21
128	3	1	20	1	6	39	44	10	54	36	20	16	48	29	10	57	35	15	10	40	35	21	56	37	17	21
129	3	0	31	1	7	45	46	23	52	24	18	23	48	24	23	48	30	18	23	55	31	18	54	31	16	19

* SEX: 0 = MALE
1 = FEMALE
* RACE: 0 = BLACK
1 = WHITE

Table A-9
Raw Data - Level 4 - Control
Western Piedmont Community College

SUBJECT	TREATMENT LEVEL	SEX*	AGE	RACE*	SELF CONCEPT	PRETEST - WORK	PRETEST - PROF	PRETEST - MIA	PRETEST - MIB	PRETEST - MIC	PRETEST - MID	PRETEST - MIE	POSTTEST - WORK	POSTTEST - PROF	POSTTEST - MIA	POSTTEST - MIB	POSTTEST - MIC	POSTTEST - MID	POSTTEST - MIE	DELAYED POST WORK	DELAYED POST PROF	DELAYED POST MIA	DELAYED POST MIB	DELAYED POST MIC	DELAYED POST MID	DELAYED POST MIE
134	4	1	29	1	1	54	56	14	54	30	15	9	54	56	10	58	35	13	9	59	64	16	51	27	17	9
135	4	1	21	1	4	51	58	25	49	26	15	16	51	55	19	49	27	19	20	57	61	23	53	30	13	20
136	4	0	27	1	8	46	31	28	57	32	14	14	52	28	23	53	32	15	23	51	26	18	49	34	17	20
137	4	0	28	1	21	43	67	21	47	35	18	17	47	56	22	49	38	14	19	36	49	29	48	38	13	22
138	4	0	18	0	31	46	36	38	47	33	36	15	52	55	44	45	33	33	24	55	48	42	44	34	31	19
139	4	1	19	0	26	46	48	22	59	39	14	13	43	33	20	49	36	16	20	46	15	26	61	42	9	13
140	4	1	21	1	3	44	60	11	51	31	9	8	39	56	14	39	29	7	9	45	64	12	48	33	9	12
141	4	1	19	1	24	51	51	15	56	41	10	16	50	59	22	51	35	13	16	52	47	17	47	32	16	14
142	4	0	22	1	14	59	69	13	46	38	8	15	57	69	23	42	33	13	16	59	63	18	40	27	20	18
143	4	1	18	1	36	50	51	23	49	29	21	13	45	64	20	46	29	22	18	45	62	17	50	29	21	18
144	4	1	19	1	3	54	58	19	51	27	21	9	56	59	26	43	28	23	13	53	62	23	48	32	20	9

* SEX: 0 = MALE
1 = FEMALE

* RACE: 0 = BLACK
1 = WHITE

APPENDIX B

Schedules and Other Forms

TREATMENT PROCEDURE - OVERALL PROCEDURE

Wayne Community College

DAY	DATE	TIME	GROUP	PERSON(S) IN CHARGE	DUTIES	NO. HOURS	ROOM	AUXILIARY PERSONS
Thursday	9-4-75	3:00-4:00	1,2,3,4	Assistants I, II, III & Experimenter	Administration of ATWP, OMI, TSCS	1	WCC	Auxiliary Personnel 2
Thursday	9-25-75	8:30-9:00	1,2,3,4	Assistants I, II, III & Experimenter	Division of Subjects Into Groups/Lunch Money/Schedules	30 min.	WCC	Auxiliary Personnel 2, Dan, Millie
Thursday	9-25-75	9:00-3:00	1 & 3	Assistants II & III	Liaison Between Sub. Supervisors-Lunch	6	C. Hosp.	Auxiliary Personnel 2
Thursday	9-25-75	9:00-12:00	2	Experimenter	Information	3	WCC	Auxiliary Personnel 2
Thursday	9-25-75	9:00-12:00	4	Assistant I	Lecture & Discussion	3	WCC	Auxiliary Personnel 2
Thursday	9-25-75	12:00-1:00	2	Experimenter	Lunch	1	WCC	
Thursday	9-25-75	12:00-1:00	4	Assistant I	Lunch	1	WCC	
Thursday	9-25-75	1:00-3:00	2		Information	2	WCC	Auxiliary Personnel 2
Friday	9-26-75	9:00-3:00	1	Assistants II & III	Liaison Between Sub. & Supervisor/Lunch	6	Cherry Hosp.	Auxiliary Personnel 1
Friday	9-26-75	9:00-12:00	2 & 3	Experimenter	Information	3	WCC	Auxiliary Personnel 2
Friday	9-26-75	9:00-12:00	4	Assistant I	Lecture & Discussion	3	WCC	Auxiliary Personnel 2
Friday	9-26-75	12:00-1:00	2 & 3	Experimenter	Lunch	1	WCC	
Friday	9-26-75	12:00-1:00	4	Assistant I	Lunch	1	WCC	
Friday	9-26-75	1:00-3:00	2 & 3	Experimenter	Information	2	WCC	Auxiliary Personnel 2
Friday	9-26-75	1:00-3:00	4	Assistant I	Lecture & Discussion	2	WCC	Auxiliary Personnel 2
Friday	9-26-75	3:00-4:00	1,2,3,4	Assistants I, II, III & Experimenter	Administration of ATWP, OMI, TSCS, Partial Debrief	1	WCC	Auxiliary Personnel 2

TREATMENT PROCEDURE - OVERALL PROCEDURE

Western Piedmont Community College

DAY	DATE	TIME	GROUP	PERSON(S) IN CHARGE	DUTIES	NO. HOURS	ROOM	AUXILIARY PERSONS
Wednesday	9-10-75	10:00-11:00	1,2,3,4	Assistants I, II, III & Experimenter	Administration of ATWP, OMI, TSCS	1	*WP-Aud.	Auxiliary Personnel 1
Tuesday	9-16-75	9:30-10:00	1,2,3,4	Assistants I, II, III & Experimenter	Division of Subjects into Groups/Pass out sheets/Lunch money	30 min.	WP	
Tuesday	9-16-75	10:00- 1:30	1 & 3	Assistants II & III	Liaison Between Subjects and supervisor(S) Lunch	3 1/2	**Br. Hosp	Auxiliary Personnel 2
Tuesday	9-16-75	10:00-11:00 12:00- 1:30	2	Experimenter	Information	2 1/2	WP	Auxiliary Personnel 1
Tuesday	9-16-75	10:00-11:00 12:00- 1:30	4	Assistant	Lecture & Discussion	2 1/2	WP	Auxiliary Personnel 1
Wednesday	9-17-75	8:00-10:00	3	Assistants II & III	Liaison Between Subjects	2	Br. Hosp	Auxiliary Personnel 1
		8:00-12:00	1	Assistants II & III	and Supervisor - Lunch	4	"	"
Wednesday	9-17-75	8:00-12:00	2	Experimenter	Information	4	WP	Auxiliary Personnel 1
		10:30-12:00	2	Experimenter	Information	1 1/2	"	"
Wednesday	9-17-75	8:00-12:00	4	Assistant I	Lecture & Discussion	4	WP	Auxiliary Personnel 1
Thursday	9-18-75	9:30- 1:30	1	Assistants II & III	Liaison between Subjects and Supervisor-Lunch	4	Br. Hosp	Auxiliary Personnel 2
Thursday	9-18-75	9:30-11:00	2	Experimenter	Information	3	WP	Auxiliary Personnel 1
		12:00- 1:30	2	Experimenter	Information	3	WP	"
Thursday	9-18-75	9:30-11:00	4	Assistant I	Lecture & Discussion	3	WP	
Tuesday	9-23-75	9:30-11:00	2 & 3	Experimenter	Information	1 1/2	WP	Auxiliary Personnel 3
Tuesday	9-23-75	9:30-11:00	1 & 4	Assistants I	Lecture & Discussion	1 1/2	WP	"
Tuesday	9-23-75	12:00- 1:30	1,2,3,4	Assistants & Experimenter	Posttest	1 1/2	WP	"

*Western Piedmont Community College
**Broughton Hospital

TREATMENT PROCEDURE - INFORMATION

Wayne Community College

DAY	DATE	TIME	GROUP	INFORMATION	NO. OF HOURS
Thursday	9-25-75	8:30-9:00	1,2,3,4	Divide Into Groups/Randomize Additional Names Give Lunch Money/Pass Out Schedules/Nina=Log Sheets & "Do's & Don'ts/ Assistants I, II, III & Experiments	30 min.
Thursday	9-25-75	9:00-10:30	2	Taped Lecture="Positive Approach to Psychiatric Patients" (Dr. Palmer) Write Down 5 Statements that Interested You Discussion="Your Emotions and Mentally Ill Persons"	1½
Thursday	9-25-75	10:30-12:00	2	Break/May Continue Discussion of Mentally Ill Persons Film-"Who Is Normal" (30 min.)	1½
Thursday	9-25-75	12:00-1:00	2	LUNCH	1
Thursday	9-25-75	1:00-3:00	2	Discussion of Film="Who Is Normal?" Read Booklet: WHAT EVERYONE SHOULD KNOW ABOUT MENTAL HEALTH Discussion of Booklet	2
Friday	9-26-75	9:00-10:00	2 & 3	Pass OUt Booklet to Group 3 - Ask Them to Read-Lunch & Break Film: "RX Attitude" - (18 min.) - Discussion	1
Friday	9-26-75	10:00-11:00	2 & 3	Lecture: "Paraprofessionals and Professionls"-Break Continue With Lecture "P and P"	1
Friday	9-26-75	11:00-12:00	2 & 3	Taped Lecture-Positive Approach to Psychiatric Patients"(30 min.) (Dr. Smith) Write Down 10 Statements that Interested You	1
Friday	9-26-75	12:00-1:00	2 & 3	LUNCH	1
Friday	9-26-75	1:00-1:30 1:30-3:00	2 & 3	Film: "Positive Approach to Psychiatric Patients"(30 min.) Discussion of Film: "PA to PP"/Break Writing of 3 one Page Paragraphs="Why I Should Have A Positive Attitude Toward Mentally Ill Patients, My Work, & Professionals Summary of Workshop	30 min. 10 min. 35 min. 15 min.
Friday	9-26-75	3:00-4:00	1,2,3,4	Posttest=ATWPS, OMI/Partial Debrief	1

Table B-4

TREATMENT PROCEDURE - INFORMATION

WESTERN PIEDMONT COMMUNITY COLLEGE

DAY	DATE	TIME	GROUP	INFORMATION	NO. OF HOURS
Tuesday	9-16-75	9:30-10:00	1,2,3,4	Divide Into Groups/Randomize Additional Names/Give Lunch Money Give Lunch Money/Pass Out Schedules/Log Sheets/"Do's & Dont's" Assistants I, II, III & Experimenter	30 min.
Tuesday	9-16-75	10:00-11:00	2	Taped Lecture="Positive Approach to Psychiatric Patients" (Dr. Palmer)/Write Down 5 Statements that Interested You Discussion="Your Emotions and Mentally Ill Persons"	1
Tuesday	9-16-75	11:00-12:00	2	LUNCH	
Tuesday	9-16-75	12:00- 2:00	2	Continue with Lecture (Dr. Palmer)/Film: "Who Is Normal?" (30 Minutes)	2
Wednesday	9-17-75	8:00-10:00	2	Read Booklet "WHAT EVERYONE SHOULD KNOW ABOUT MENTAL HEALTH" Discussion of Booklet Film: "RX Attitude" -- Discussion	2
Wednesday	9-17-75	10:00-12:00	2 & 3	Pass Out Booklet to Group 3 - Ask Them to Read Lecture: "Paraprofessionals and Professionals"	1
Thursday	9-18-75	9:30-11:00	2 & 3	Taped Lecture: Positive Approach to Psychiatric Patients (Dr. Smith) Write Down 10 Statements That Interested You	1½
Thursday	9-18-75	11:00-12:00		LUNCH	
Thursday	9-18-75	12:00- 1:30	2 & 3	Discussion of Film: "PA to PP" Writing of 3 one page paragraphs-Topic: "Why I Should Have A Positive Attitude Toward Mentally Ill Patients, My Work and Professionals"	1½
Tuesday	9-23-75	9:30-10:30	2 & 3 1 & 4	Summary of Workshop - Experimenter Summary of Workshop - Assistant I	1
Tuesday	9-23-75	10:30-12:00	1,2,3,4	Posttest	1½

STUDENTS' GUIDELINE FOR PATIENTS

"DO'S and DON'T'S"

PLEASE READ CAREFULLY!

You will be interacting with the patient in the role of a "friend" NOT a therapist. Listen carefully to the person(s) in charge, and follow his/her direction at all times. Below are some additional DO'S and DON'T'S.

A. DO'S

1. Listen attentively to patients and supervisor.
2. Talk in a well modulated voice to all persons.
3. Interact with the patient verbally and/or behaviorally ONLY if it is permissible with the supervisor or the person in charge.
4. Be understanding, kind, and firm.
5. Treat the patient as you would like to be treated--empathize.
6. Respect the patient's rights.
7. Be courteous.
8. REMEMBER--maintaining CONFIDENTIALITY relative to information about the patient is YOUR RESPONSIBILITY also!
9. BE HELPFUL!

B. DON'T'S

10. Do not get in the way.
11. Do not be punitive and judgmental.
12. Do not be overcritical.
13. Do not talk about the patient in his/her presence.

14. Do not abuse or threaten.

15. Avoid excitement.

16. Do not lie or deceive.

NOTE: One out of ten persons, at sometime in his life, is in need of some type of therapy. The next person could be one of us, a relative, or a friend.

SUBJECT'S FORMAT FOR LOG WITH PATIENT

Name _____

Place _____
(Hospital)

Type of Therapy _____

Date _____

DIRECTIONS: Please supply the information requested below. All information will be confidential. Thank you.

DAY	HOUR A.M.	HOUR P.M.	ACTIVITIES ENGAGED IN

A. INTERACTION WITH PATIENTS (Please check one)

a. _____ Positive b. _____ Adequate c. _____ Negative

B. YOUR PERCEPTION OF SUPERVISOR'S ATTITUDE TOWARD YOU (Please check one)

a. _____ Positive b. _____ Adequate c. _____ Negative

C. YOUR ATTITUDE TOWARD THE SUPERVISOR (Please check one)

a. _____ Positive b. Adequate c. Negative

POSITIVE ATTITUDES TOWARD MENTAL ILLNESS,

MY WORK AND PROFESSIONALS

DIRECTIONS: Please write a one page paragraph on each of the following subjects as designated. You may use the back side of the paper for any extra.

A. "Why I Should Have A Positive Attitude Toward Mentally Ill Patients"

B. "Why I Should Have A Positive Attitude Toward My Work as A Paraprofessional In Community Mental Health"

C. "Why I Should Have A Positive Attitude Toward Professionals In Community Mental Health"

SUMMARY OF MINI-WORKSHOP

Community Mental Health

DIRECTIONS: Please meditate for _____ minutes on the activities in which you have engaged for the past several days. Then write a summary of the same on the sheets provided. Thank you.

EXPERIMENTER, SUBJECTS AND PHYSICAL ENVIRONMENT

CHECKLIST

Name of Rater _____ Place _____ (School)

Group Rated _____ (contact, info, contact-info) control

Date _____

PART I. EXPERIMENTER'S BEHAVIOR

DIRECTIONS: Please circle only one response for each numbered item, and supply additional information, if any, where requested. Thank you.

1. The experimenter's instructions to subjects were:

   a. Good b. Average c. Poor

2. The experimenter's answering of questions was:

   a. Good b. Average c. Poor

3. The experimenter anticipated subjects' difficulties before they arose:

   a. Good b. Average c. Poor

4. The experimenter put her materials over in an interesting way.

   a. Good b. Average c. Poor

5. The experimenter decided in detail what should be done and how it should be done.

   a. Good b. Average c. Poor

6. The experimenter had everything going according to schedule.

   a. Good b. Average c. Poor

7. The experimenter's tone of voice was:

   a. Good b. Average c. Poor

8. The experimenter explained clearly, and her explanations were to the point.

   a. Good b. Average c. Poor

9. The experimenter exhibited the same type of behavior with all groups.

   a. Good b. Average c. Poor

10. The experimenter's overall demeanor was:

   a. Good b. Average c. Poor

11. The experimenter listened attentively to what subjects had to say.

   a. Good b. Average c. Poor

12. The experimenter was friendly.

   a. Good b. Average c. Poor

NOTE: Please make any additional comments relative to the behavior exhibited by the experimenter _____

_____

_____

_____

_____

PART II. SUBJECT'S BEHAVIOR

DIRECTIONS: Please circle only one response for each numbered item, and supply additional information, if any, where requested. Thank you.

13. Subjects were attentive to instructions.

   a. Good b. Average c. Poor

14. Subjects understood directions and/or instructions.

   a. Good b. Average c. Poor

15. Subjects appeared to be friendly.

   a. Good b. Average c. Poor

16. Subjects appeared to be enthusiastic.

    a. Good b. Average c. Poor

NOTE: Please make any additional comments of interest relative to subject's behavior _____

_____

_____

_____

_____

PART III. PHYSICAL ENVIRONMENT

DIRECTIONS: Please circle only one response for each numbered item, and supply additional information, if any, where requested. Thank you.

17. The lighting in the room was:

    a. Good b. Average (adequate) c. Poor

18. The desks (seating) in the room were:

    a. Good b. Adequate c. Poor

19. The temperature in the room was:

    a. Good b. Adequate c. Poor

20. The noise level outside the treatment program room was:

    a. Low b. Medium c. High

21. The number of unusual events occurring while the treatment program was in progress was:

    a. None b. Very few c. Several

List unusual events if any: _____

_____

_____

NOTE: Please make additional comments relative to physical environment if you think they are important _____

_____

_____

_____

_____

_____

SCHEDULE - GROUP I
Wayne Community College
Students' Copy

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Thursday	9-4-75	WCC ____	3:00-4:00	Assistants I, II, III & Experimenter	Auxiliary Personnel-2
Thursday	9-25-75	WCC ____	8:30-9:00	Assistants I, II, III & Experimenter	"
Thursday	9-25-75	Cherry Hosp./ Therapeutic Center	9:00-3:00 Lunch	Assistants II & III	Auxiliary Personnel-1
Friday	9-26-75	Cherry Hosp./ Therapeutic Center	9:00-3:00 Lunch	Assistants II & III	"
Friday	9-26-75	WCC ____	3:00-4:00	Assistants I, II, III & Experimenter	"

SCHEDULE - GROUP II
Wayne Community College
Students' Copy

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Thursday	9-4-75	WCC ____	3:00-4:00	Assistants I, II, III & Experimenter	Auxiliary Personnel-2
Thursday	9-25-75	WCC ____	8:30-9:00	Assistants I, II, III & Experimenter	"
Thursday	9-25-75	WCC ____	9:00-12:00	Experimenter	"
Thursday	9-25-75	WCC ____	12:00-1:00	LUNCH	"
Thursday	9-25-75	WCC ____	1:00-3:00	Experimenter	"
Friday	9-26-75	WCC ____	9:00-12:00	Experimenter	"
Friday	9-26-75	WCC ____	12:00-1:00	LUNCH	"
Friday	9-26-75	WCC ____	1:00-3:00	Experimenter	"
Friday	9-26-75	WCC ____	3:00-4:00	Assistants I, II, III & Experimenter	"

SCHEDULE - GROUP III
Wayne Community College
Students' Copy

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Thursday	9-4-75	WCC ____	3:00- 4:00	Assistants I, II, III & Experimenter	Auxiliary Personnel-2
Thursday	9-25-75	WCC ____	8:30- 9:00	Assistants I, II, III & Experimenter	"
Thursday	9-25-75	Cherry Hosp./ Therapeutic Center	9:00- 3:00 Lunch	Assistants II & III	Auxiliary Personnel-1
Friday	9-26-75	WCC ____	9:00-12:00	Experimenter	Auxiliary Personnel-2
Friday	9-26-75	WCC ____	12:00- 1:00	LUNCH	"
Friday	9-26-75	WCC ____	1:00- 3:00	Experimenter	"
Friday	9-26-75	WCC ____	3:00- 4:00	Assistants I, II, III & Experimenter	"

SCHEDULE - GROUP IV
Wayne Community College
Students' Copy

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Thursday	9-4-75	WCC ____	3:00- 4:00	Assistants I, II, III & Experimenter	Auxiliary Personnel-2
Thursday	9-25-75	WCC ____	8:30- 9:00	Assistants I, II, III & Experimenter	"
Thursday	9-25-75	WCC ____	9:00-12:00	Assistant I	"
Thursday	9-25-75	WCC ____	12:00- 1:00	LUNCH	"
Thursday	9-25-75	WCC ____	1:00- 3:00	Assistant I	"
Friday	9-26-75	WCC ____	9:00-12:00	Assistant I	"
Friday	9-26-75	WCC ____	12:00- 1:00	LUNCH	"
Friday	9-26-75	WCC ____	1:00- 3:00	Assistant I	"
Friday	9-26-75	WCC ____	3:00- 4:00	Assistants I, II, III & Experimenter	"

SCHEDULE - GROUP I
Western Piedmont Community College
Students' Copy

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Wednesday	9-10-75	W. P. Aud.	10:00-11:00	Assistants I, II, III & Experimenter	Auxiliary Personnel-3
Tuesday	9-16-75	W. P. ____	9:30-10:00	Assistants I, II, III & Experimenter	"
Tuesday	9-16-75	Broughton Hospital/ Ward A--Lunch	10:00- 1:30	Assistants II & III	"
Wednesday	9-17-75	Broughton Hospital/ Ward A	8:00-12:00	Assistants II & III	"
Thursday	9-18-75	Broughton Hospital/ Ward A--Lunch	9:30-1:30	Assistants II & III	"
Tuesday	9-23-75	W. P. ____	9:30-11:00	Assistant I	"
Tuesday	9-23-75	W. P. ____	11:00-12:00	LUNCH	"
Tuesday	9-23-75	W. P. ____	12:00- 1:30	Assistant I & Experimenter	"
Wednesday	9-24-75	W. P. ____	10:00-11:00	Assistants I, II, III & Experimenter	"

SCHEDULE - GROUP II
Western Piedmont Community College
Students' Copy

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Wednesday	9-10-75	W. P. Aud.	10:00-11:00	Assistants I, II, III & Experimenter	Auxiliary Personnel-3
Tuesday	9-16-75	W. P. ____	9:30-10:00	Assistants I, II, III & Experimenter	"
Tuesday	9-16-75	W. P. ____	10:00-11:00	Experimenter	"
Tuesday	9-16-75	W. P. ____	11:00-12:00	LUNCH	"
Tuesday	9-16-75	W. P. ____	12:00- 1:30	Experimenter	"
Wednesday	9-17-75	W. P. ____	8:00-12:00	Experimenter	"
Thursday	9-18-75	W. P. ____	9:30-11:00	Experimenter	"
Thursday	9-18-75	W. P. ____	11:00-12:00	LUNCH	"
Thursday	9-18-75	W. P. ____	12:00- 1:30	Experimenter	"

SCHEDULE - GROUP II (Continued)
Western Piedmont Community College

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Tuesday	9-23-75	W. P. ____	9:30-11:00	Experimenter	Auxiliary Personnel-3
Tuesday	9-23-75	W. P. ____	11:00-12:00	LUNCH	"
Tuesday	9-23-75	W. P. ____	12:00- 1:30	Assistant I & Experimenter	"
Wednesday	9-24-75	W. P. ____	10:00-11:00	Assistants I, II, III & Experimenter	"

SCHEDULE - GROUP III
Western Piedmont Community College
Students' Copy

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Wednesday	9-10-75	W. P. Aud.	10:00-11:00	Assistants I, II, III & Experimenter	Auxiliary Personnel-3
Tuesday	9-16-75	W. P. ____	9:30-10:00	Assistants I, II, III & Experimenter	"
Tuesday	9-16-75	Broughton Hospital/ Ward A & Lunch	10:00- 1:30	Assistants I & II	"
Wednesday	9-17-75	Broughton Hospital/ Ward A	8:00-10:00	Assistants II & III	"
Wednesday	9-17-75	W. P. ____	10:00-12:00	Experimenter	"
Thursday	9-18-75	W. P. ____	9:30-11:00	Experimenter	"
Thursday	9-18-75	W. P. ____	11:00-12:00	LUNCH	"
Thursday	9-18-75	W. P. ____	12:00- 1:30	Experimenter	"
Tuesday	9-23-75	W. P. ____	9:30-11:00	Experimenter	"

SCHEDULE - GROUP III (Continued)
Western Piedmont Community College

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Tuesday	9-23-75	W. P. ____	11:00-12:00	LUNCH	Auxiliary Personnel-3
Tuesday	9-23-75	W. P. ____	12:00- 1:30	Assistant I & Experimenter	"
Wednesday	9-24-75	W. P. ____	10:00-11:00	Assistants I, II, III & Experimenter	"

SCHEDULE - GROUP IV
Western Piedmont Community College
Students' Copy

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Wednesday	9-10-75	W. P. Aud.	10:00-11:00	Assistants I, II, III & Experimenter	Auxiliary Personnel-3
Tuesday	9-16-75	W. P. ____	9:30-10:00	Assistants I, II, III & Experimenter	"
Tuesday	9-16-75	W. P. ____	10:00-11:00	Assistant I	"
Tuesday	9-16-75	W. P. ____	11:00-12:00	LUNCH	"
Tuesday	9-16-75	W. P. ____	12:00- 1:30	Assistant I	"
Wednesday	9-17-75	W. P. ____	8:00-12:00	Assistant I	"
Thursday	9-18-75	W. P. ____	9:30-11:00	Assistant I	"
Thursday	9-18-75	W. P. ____	11:00-12:00	LUNCH	"
Thursday	9-18-75	W. P. ____	12:00- 1:30	Assistant I	"

SCHEDULE - GROUP IV (Continued)
Western Piedmont Community College

DAY	DATE	PLACE	TIME	PERSON(S) IN CHARGE	AUXILIARY PERSONS
Tuesday	9-23-75	W. P. ____	9:30-11:00	Assistant I	Auxiliary Personnel-3
Tuesday	9-23-75	W. P. ____	11:00-12:00	LUNCH	"
Tuesday	9-23-75	W. P. ____	12:00- 1:30	Assistant I & Experimenter	"
Wednesday	9-24-75	W. P. ____	10:00-11:00	Assistants I, II, III & Experimenter	"

APPENDIX C

Research Instruments

C-1

OPINIONS ABOUT MENTAL ILLNESS

Jacob Cohen
Elmer L. Struening

The statements that follow are opinions or ideas about mental illness and mental patients. By mental illness, we mean the kinds of illness which bring patients to mental hospitals, and by mental patients we mean mental hospital patients. There are many differences of opinion about this subject. In other words, many people agree with each of the following statements while many people disagree with each of these statements. We would like to know what you think about these statements. Each of them is followed by six choices:

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

Please check (√) in the space provided that choice which is closest to saying how you feel about each statement. You can be sure that many people, including doctors, will agree with your choice. There are no right or wrong answers: we are interested only in your opinion. It is very important that you answer every item.

* * * * *

1. NERVOUS BREAKDOWNS USUALLY RESULT WHEN PEOPLE WORK TOO HARD.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

2. MENTAL ILLNESS IS AN ILLNESS LIKE ANY OTHER.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

3. MOST PATIENTS IN MENTAL HOSPITALS ARE NOT DANGEROUS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

2.

4. ALTHOUGH PATIENTS DISCHARGED FROM MENTAL HOSPITALS MAY SEEM ALL RIGHT, THEY SHOULD NOT BE ALLOWED TO MARRY.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

5. IF PARENTS LOVED THEIR CHILDREN MORE, THERE WOULD BE LESS MENTAL ILLNESS.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

6. IT IS EASY TO RECOGNIZE SOMEONE WHO ONCE HAD A SERIOUS MENTAL ILLNESS.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

7. PEOPLE WHO ARE MENTALLY ILL LET THEIR EMOTIONS CONTROL THEM: NORMAL PEOPLE THINK THINGS OUT.

strongly___ agree___ not sure but___ not sure but___ disagree___ strongly___
agree probably agree probably disagree disagree

8. PEOPLE WHO WERE ONCE PATIENTS IN MENTAL HOSPITALS ARE NO MORE DANGEROUS THAN THE AVERAGE CITIZEN.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

9. WHEN A PERSON HAS A PROBLEM OR A WORRY, IT IS BEST NOT TO THINK ABOUT IT, BUT KEEP BUSY WITH MORE PLEASANT THINGS.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

10. ALTHOUGH THEY USUALLY AREN'T AWARE OF IT, MANY PEOPLE BECOME MENTALLY ILL TO AVOID THE DIFFICULT PROBLEMS OF EVERYDAY LIFE.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

11. THERE IS SOMETHING ABOUT MENTAL PATIENTS THAT MAKES IT EASY TO TELL THEM FROM NORMAL PEOPLE.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

12. EVEN THOUGH PATIENTS IN MENTAL HOSPITALS BEHAVE IN FUNNY WAYS, IT IS WRONG TO LAUGH ABOUT THEM.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

13. MOST MENTAL PATIENTS ARE WILLING TO WORK.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

14. THE SMALL CHILDREN OF PATIENTS IN MENTAL HOSPITALS SHOULD NOT BE ALLOWED TO VISIT THEM.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

15. PEOPLE WHO ARE SUCCESSFUL IN THEIR WORK SELDOM BECOME MENTALLY ILL.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

16. PEOPLE WOULD NOT BECOME MENTALLY ILL IF THEY AVOIDED BAD THOUGHTS.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

17. PATIENTS IN MENTAL HOSPITALS ARE IN MANY WAYS LIKE CHILDREN.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

18. MORE TAX MONEY SHOULD BE SPENT IN THE CARE AND TREATMENT OF PEOPLE WITH SEVERE MENTAL ILLNESS.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

19. A HEART PATIENT HAS JUST ONE THING WRONG WITH HIM, WHILE A MENTALLY ILL PERSON IS COMPLETELY DIFFERENT FROM OTHER PATIENTS.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

20. MENTAL PATIENTS COME FROM HOMES WHERE THE PARENTS TOOK LITTLE INTEREST IN THEIR CHILDREN.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

21. PEOPLE WITH MENTAL ILLNESS SHOULD NEVER BE TREATED IN THE SAME HOSPITAL AS PEOPLE WITH PHYSICAL ILLNESS.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

4.

22. ANYONE WHO TRIES HARD TO BETTER HIMSELF DESERVES THE RESPECT OF OTHERS.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

23. IF OUR HOSPITALS HAD ENOUGH WELL TRAINED DOCTORS, NURSES, AND AIDES, MANY OF THE PATIENTS WOULD GET WELL ENOUGH TO LIVE OUTSIDE THE HOSPITAL.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

24. A WOMAN WOULD BE FOOLISH TO MARRY A MAN WHO HAS HAD A SEVERE MENTAL ILLNESS, EVEN THOUGH HE SEEMS FULLY RECOVERED.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

25. IF THE CHILDREN OF MENTALLY ILL PARENTS WERE RAISED BY NORMAL PARENTS, THEY WOULD PROBABLY NOT BECOME MENTALLY ILL.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

26. PEOPLE WHO HAVE BEEN PATIENTS IN A MENTAL HOSPITAL WILL NEVER BE THEIR OLD SELVES AGAIN.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

27. MANY MENTAL PATIENTS ARE CAPABLE OF SKILLED LABOR, EVEN THOUGH IN SOME WAYS THEY ARE VERY DISTURBED MENTALLY.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

28. OUR MENTAL HOSPITALS SEEM MORE LIKE PRISONS THAN LIKE PLACES WHERE MENTALLY ILL PEOPLE CAN BE CARED FOR.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

29. ANYONE WHO IS IN A HOSPITAL FOR A MENTAL ILLNESS SHOULD NOT BE ALLOWED TO VOTE.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

30. THE MENTAL ILLNESS OF MANY PEOPLE IS CAUSED BY THE SEPARATION OR DIVORCE OF THEIR PARENTS DURING CHILDHOOD.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

5.

31. THE BEST WAY TO HANDLE PATIENTS IN MENTAL HOSPITALS IS TO KEEP THEM BEHIND LOCKED DOORS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

32. TO BECOME A PATIENT IN A MENTAL HOSPITAL IS TO BECOME A FAILURE IN LIFE.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

33. THE PATIENTS OF MENTAL HOSPITALS SHOULD BE ALLOWED MORE PRIVACY.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

34. IF A PATIENT IN A MENTAL HOSPITAL ATTACKS SOMEONE, HE SHOULD BE PUNISHED SO HE DOESN'T DO IT AGAIN.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

35. IF THE CHILDREN OF NORMAL PARENTS WERE RAISED BY MENTALLY ILL PARENTS, THEY WOULD PROBABLY BECOME MENTALLY ILL.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

36. EVERY MENTAL HOSPITAL SHOULD BE SURROUNDED BY A HIGH FENCE AND GUARDS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

37. THE LAW SHOULD ALLOW A WOMAN TO DIVORCE HER HUSBAND AS SOON AS HE HAS BEEN CONFINED IN A MENTAL HOSPITAL WITH A SEVERE MENTAL ILLNESS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

38. PEOPLE (BOTH VETERANS AND NON-VETERANS) WHO ARE UNABLE TO WORK BECAUSE OF MENTAL ILLNESS SHOULD RECEIVE MONEY FOR LIVING EXPENSES.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

39. MENTAL ILLNESS IS USUALLY CAUSED BY SOME DISEASE OF THE NERVOUS SYSTEM.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree_____ disagree___ strongly disagree___

6.

40. REGARDLESS OF HOW YOU LOOK AT IT, PATIENTS WITH SEVERE MENTAL ILLNESS ARE NO LONGER REALLY HUMAN.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

41. MOST WOMEN WHO WERE ONCE PATIENTS IN A MENTAL HOSPITAL COULD BE TRUSTED AS BABY SITTERS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

42. MOST PATIENTS IN MENTAL HOSPITALS DON'T CARE HOW THEY LOOK.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

43. COLLEGE PROFESSORS ARE MORE LIKELY TO BECOME MENTALLY ILL THAN ARE BUSINESS MEN.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

44. MANY PEOPLE WHO HAVE NEVER BEEN PATIENTS IN A MENTAL HOSPITAL ARE MORE MENTALLY ILL THAN MANY HOSPITALIZED MENTAL PATIENTS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

45. ALTHOUGH SOME MENTAL PATIENTS SEEM ALL RIGHT, IT IS DANGEROUS TO FORGET FOR A MOMENT THAT THEY ARE MENTALLY ILL.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

46. SOMETIMES MENTAL ILLNESS IS PUNISHMENT FOR BAD DEEDS.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

47. OUR MENTAL HOSPITALS SHOULD BE ORGANIZED IN A WAY THAT MAKES THE PATIENT FEEL AS MUCH AS POSSIBLE LIKE HE IS LIVING AT HOME.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

48. ONE OF THE MAIN CAUSES OF MENTAL ILLNESS IS A LACK OF MORAL STRENGTH OR WILL POWER.

strongly agree___ agree___ not sure but probably agree___ not sure but probably disagree___ disagree___ strongly disagree___

49. THERE IS LITTLE THAT CAN BE DONE FOR PATIENTS IN A MENTAL HOSPITAL EXCEPT TO SEE THAT THEY ARE COMFORTABLE AND WELL FED.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

50. MANY MENTAL PATIENTS WOULD REMAIN IN THE HOSPITAL UNTIL THEY WERE WELL, EVEN IF THE DOORS WERE UNLOCKED.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

51. ALL PATIENTS IN MENTAL HOSPITALS SHOULD BE PREVENTED FROM HAVING CHILDREN BY A PAINLESS OPERATION.

strongly___ agree___ not sure but___ not sure but_____ disagree___ strongly___
agree probably agree probably disagree disagree

PLEASE CHECK BACK AND MAKE SURE THAT YOU HAVE NOT LEFT OUT ANY STATEMENTS

OR PAGES OF STATEMENTS

PLEASE MAKE SURE YOU COMPLETE THE FOLLOWING PAGE

52. AGE_____ 53. SEX: Male____ Female _____

54. HOW MANY YEARS OF SCHOOL HAVE YOU COMPLETED? (from the first grade_____)

55. OCCUPATION OF PRIMARY WAGE EARNER? (Please list specific job performed.)

_____

56. RELIGIOUS PREFERENCE:

_____ PROTESTANT (Please specify)

_____ CATHOLIC

_____ JEWISH

_____ OTHER (Please specify)

_____

Name of Student Class Hour

_____

Name of Person Completing This Form Relationship to Student

_____

Address City Phone

I consent to have my (son, daughter) participate in a research project related to the course of work of Psychology 3.

_____

Signature

C-2

ATTITUDE TOWARD WORK AND PROFESSIONALS SCALE

PART I. MY WORK - COMMUNITY MENTAL HEALTH

Please place an "X" under the column "Yes," "No," or "Undecided" for every description that you think is related to your work as a paraprofessional. ALL INFORMATION IS CONFIDENTIAL. Thank you.

ADJECTIVE	YES	NO	UNDECIDED
1. Fascinating			
2. Routine			
3. Satisfying			
4. Boring			
5. Good			
6. Creative			
7. Respected			
8. Hot			
9. Pleasant			
10. Useful			
11. Tiresome			
12. Healthful			
13. Challenging			
14. On Your Feet			
15. Frustrating			
16. Simple			
17. Endless			
18. Gives Sense of Accomplishment			

ADJECTIVE	YES	NO	UNDECIDED
19. Good Opportunity for Advancement.....			
20. Opportunity Somewhat Limited.....			
21. Dead-end Job.....			

PART II. ATTITUDE TOWARD PROFESSIONALS - COMMUNITY MENTAL ILLNESS

DIRECTIONS: For each of the following items, please circle a, b, OR c. If you have not had any actual contact with professionals thus far, answer the following questions on the basis of what you think your reactions to professionals will be, and what you think their reactions to you will be. Be sure to answer each question. Thank you.

1. Professionals believe that the use of paraprofessionals will threaten their jobs.

   a. Yes b. No c. Undecided

2. Professionals believe that the use of paraprofessionals will eventually result in the deterioration of professional standards.

   a. Yes b. No c. Undecided

3. Most professionals would hesitate to be a co-therapist with a paraprofessional in group counseling situations.

   a. Yes b. No c. Undecided

4. Professionals believe that the need for more service personnel should first be met by training more professionals and only then by using paraprofessionals.

   a. Yes b. No c. Undecided

5. Professionals believe that paraprofessionals should only be used as clerks and secretaries.

   a. Yes b. No c. Undecided

6. Professionals believe that if paraprofessionals were used in great numbers, the quality of professional service would go down.

   a. Yes b. No c. Undecided

7. Professionals believe that paraprofessionals should not engage in psychotherapy.

   a. Yes b. No c. Undecided

8. Professionals believe that the activities of paraprofessionals should not include the supervision of other paraprofessionals.

   a. Yes b. No c. Undecided

9. Professionals believe that paraprofessionals could work effectively with them in other agencies than their own to facilitate the management of cases.

   a. Yes b. No c. Undecided

10. Professionals believe that the roles of the paraprofessionals should be kept quite distinct from theirs.

    a. Yes b. No c. Undecided

11. Professionals believe that the use of paraprofessionals would greatly enhance the continuity of care.

    a. Yes b. No c. Undecided

12. Professionals believe that paraprofessionals would have a difficult time in making proper referrals.

    a. Yes b. No c. Undecided

13. Professionals believe that the activities of paraprofessionals should not be restricted to work outside the agency.

    a. Yes b. No c. Undecided

14. Professionals believe that in agencies using the team system, paraprofessionals should be considered along with them as possible team leaders.

    a. Yes b. No c. Undecided

15. Professionals believe that it is to the advantage of profession mental health workers to work toward the utilization of paraprofessionals.

    a. Yes b. No c. Undecided

16. Professionals believe that paraprofessionals should be able to give quality consultative services to the schools.

    a. Yes b. No c. Undecided

17. With your experience with professionals, their instructions to you were:

    a. Good b. Average c. Poor

18. You think the professional does or will perform his/her duties with confidence.

    a. Good b. No c. Undecided

19. You know or think that the professional's attitude toward you is or will be:

    a. Good b. Average c. Poor

20. You think that your association with professionals does or will increase your interest in community mental health:

    a. Good(Much) b. Average c. Poor(Little)

21. Your feeling of being at ease with professionals is or will be:

    a. Good b. Average c. Poor

22. The professional's appreciation of your work ti or will be:

    a. Good b. Average c. Poor

23. My association with professionals in community mental health is or will be:

    a. Good b. Average c. Poor

PART III. PLEASE COMPLETE. ALL INFORMATION IS CONFIDENTIAL. THANK YOU.

A. NAME. _____

B. ETHNIC GROUP.

1. _____ Black
2. _____ White
3. _____ Other

C. SEX.

1. _____ Female
2. _____ Male

D. AGE. _____

E. MARITAL STATUS.

1. _____ Single
2. _____ Married
3. _____ Divorced
4. _____ Separated
5. _____ Living With Member of Opposite Sex
6. _____ Living With Member of Same Sex
7. _____ Other

F. NAME OF SCHOOL ATTENDING AT PRESENT. _____

_____

G. PREVIOUS ACADEMIC TRAINING.

1. _____ Diploma-High School or Equivalent
2. _____ Associate Degree
3. _____ Bachelor Degree
4. _____ Other

H. DATE. _____

C-3

TENNESSEE

SELF CONCEPT SCALE

by

William H. Fitts, PhD.

Published by

Counselor Recordings and Tests

Box 6184 - Acklen Station Nashville, Tennessee 37212

Page 1

	Item No.
1. I have a healthy body	1
3. I am an attractive person	3
5. I consider myself a sloppy person	5
19. I am a decent sort of person	19
21. I am an honest person	21
23. I am a bad person	23
37. I am a cheerful person	37
39. I am a calm and easy going person	39
41. I am a nobody	41
55. I have a family that would always help me in any kind of trouble	55
57. I am a member of a happy family	57
59. My friends have no confidence in me	59
73. I am a friendly person	73
75. I am popular with men	75
77. I am not interested in what other people do	77
91. I do not always tell the truth	91
93. I get angry sometimes	93

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

	Item No.
2. I like to look nice and neat all the time	[redacted]
4. I am full of aches and pains	[redacted]
6. I am a sick person	[redacted]
20. I am a religious person	[redacted]
22. I am a moral failure	[redacted]
24. I am a morally weak person	[redacted]
38. I have a lot of self-control	[redacted]
40. I am a hateful person	[redacted]
42. I am losing my mind	[redacted]
56. I am an important person to my friends and family	[redacted]
58. I am not loved by my family	[redacted]
60. I feel that my family doesn't trust me	[redacted]
74. I am popular with women	[redacted]
76. I am mad at the whole world	[redacted]
78. I am hard to be friendly with	[redacted]
92. Once in a while I think of things too bad to talk about	[redacted]
94. Sometimes, when I am not feeling well, I am cross	[redacted]

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

	Item No.
7. I am neither too fat nor too thin	7
9. I like my looks just the way they are	9
11. I would like to change some parts of my body	11
25. I am satisfied with my moral behavior	25
27. I am satisfied with my relationship to God	27
29. I ought to go to church more	29
43. I am satisfied to be just what I am	43
45. I am just as nice as I should be	45
47. I despise myself	47
61. I am satisfied with my family relationships	61
63. I understand my family as well as I should	63
65. I should trust my family more	65
79. I am as sociable as I want to be	79
81. I try to please others, but I don't overdo it	81
83. I am no good at all from a social standpoint	83
95. I do not like everyone I know	95
97. Once in a while, I laugh at a dirty joke	97

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

Page 4

		Item No.
8.	I am neither too tall nor too short	
10.	I don't feel as well as I should	
12.	I should have more sex appeal	
26.	I am as religious as I want to be	
28.	I wish I could be more trustworthy	
30.	I shouldn't tell so many lies	
44.	I am as smart as I want to be	
46.	I am not the person I would like to be	
48.	I wish I didn't give up as easily as I do	
62.	I treat my parents as well as I should (Use past tense if parents are not living)	
64.	I am too sensitive to things my family say	
66.	I should love my family more	
80.	I am satisfied with the way I treat other people	
82.	I should be more polite to others	
84.	I ought to get along better with other people	
96.	I gossip a little at times	
98.	At times I feel like swearing	

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

Page 5

		Item No.
13.	I take good care of myself physically	13
15.	I try to be careful about my appearance	15
17.	I often act like I am "all thumbs"	17
31.	I am true to my religion in my everyday life	31
33.	I try to change when I know I'm doing things that are wrong	33
35.	I sometimes do very bad things	35
49.	I can always take care of myself in any situation	49
51.	I take the blame for things without getting mad	51
53.	I do things without thinking about them first	53
67.	I try to play fair with my friends and family	67
69.	I take a real interest in my family	69
71.	I give in to my parents. (Use past tense if parents are not living)	71
85.	I try to understand the other fellow's point of view	85
87.	I get along well with other people	87
89.	I do not forgive others easily	89
99.	I would rather win than lose in a game	99

Responses -	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

		Item No.
14.	I feel good most of the time	[redacted]
16.	I do poorly in sports and games	[redacted]
18.	I am a poor sleeper	[redacted]
32.	I do what is right most of the time	[redacted]
34.	I sometimes use unfair means to get ahead	[redacted]
36.	I have trouble doing the things that are right	[redacted]
50.	I solve my problems quite easily	[redacted]
52.	I change my mind a lot	[redacted]
54.	I try to run away from my problems	[redacted]
68.	I do my share of work at home	[redacted]
70.	I quarrel with my family	[redacted]
72.	I do not act like my family thinks I should	[redacted]
86.	I see good points in all the people I meet	[redacted]
88.	I do not feel at ease with other people	[redacted]
90.	I find it hard to talk with strangers	[redacted]
100.	Once in a while I put off until tomorrow what I ought to do today	[redacted]

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

APPENDIX D

Tables of Means

TABLE D-1

PRETEST, POSTTEST AND DELAYED POST -- OMI

MEANS AND STANDARD DEVIATIONS ON ALL LEVELS
Wayne Community College

TREATMENT LEVEL		AUTHORIANISM			BENEVOLENCE			MENTAL HYGIENE IDEOLOGY			SOCIAL RESTRICTIVENESS			INTERPERSONAL ETIOLOGY			*NUMBER OF SUBJECTS
		PRETEST	POSTTEST	DELAYED POSTTEST	PRETEST	POSTTEST	DELAYED POSTTEST	PRETEST	POSTTEST	DELAYED POSTTEST	PRETEST	POSTTEST	DELAYED POSTTEST	PRETEST	POSTTEST	DELAYED POSTTEST	
I	M	25.9	25.0	24.9	51.3	53.6	53.3	33.2	32.3	32.7	19.3	16.8	17.2	18.3	20.3	18.1	
	SD	5.7	7.0	17.5	5.9	6.4	7.7	5.5	5.7	8.0	6.4	6.3	7.8	4.9	5.4	7.1	
II	M	27.3	24.9	24.6	50.1	49.9	50.4	29.3	29.4	30.9	18.7	21.1	22.0	15.1	15.1	19.6	
	SD	5.9	6.9	6.8	5.3	7.0	5.2	5.2	3.7	5.6	6.3	5.3	8.0	4.8	4.2	5.2	
III	M	24.3	24.2	24.8	52.3	53.8	55.2	31.7	32.6	32.1	19.1	18.7	16.8	14.4	14.0	14.3	
	SD	7.1	8.3	7.3	5.3	6.1	4.8	4.2	5.2	5.8	5.1	6.4	7.4	5.9	4.3	4.3	
IV	M	28.5	26.5	24.2	50.1	50.0	50.8	32.0	32.0	33.1	20.3	20.8	20.9	15.8	17.1	15.1	
	SD	7.7	5.8	7.5	8.7	6.1	8.0	4.3	6.3	5.3	4.0	5.7	6.0	3.8	3.1	5.6	

*$\underline{n}$ = 12 for each level

TABLE D-2

PRETEST, POSTTEST, DELAYED POST - ATWPS*

MEANS AND STANDARD DEVIATIONS ON ALL LEVELS

Wayne Community College

TREATMENT		WORK			PROFESSIONALS		
LEVEL		PRETEST	POSTTEST	DELAYED POST	PRETEST	POSTTEST	DELAYED POST
I	M	45.7	51.9	50.0	42.9	41.9	33.7
	SD	10.6	4.9	12.6	14.8	10.5	14.0
II	M	47.0	47.0	50.0	48.6	51.0	45.7
	SD	7.3	9.0	7.9	6.7	7.2	12.0
III	M	48.8	49.1	46.9	50.1	44.5	41.9
	SD	2.7	6.3	8.2	11.0	11.9	17.0
IV	M	51.7	51.2	53.2	48.6	44.7	46.9
	SD	4.3	6.5	6.3	14.7	13.5	13.7

*Attitude Toward Work and Professionals Scale

TABLE D-3

PRETEST, POSTTEST AND DELAYED POST -- OMI

MEANS AND STANDARD DEVIATIONS ON ALL LEVELS
Western Piedmont Community College

TREATMENT LEVEL		AUTHORIANISM			BENEVOLENCE			MENTAL HYGIENE IDEOLOGY			SOCIAL RESTRICTIVENESS			INTERPERSONAL ETIOLOGY			NUMBER OF SUBJECTS
		PRETEST	POSTTEST	DELAYED POSTTEST	PRETEST	POSTTEST	DELAYED POSTTEST	PRETEST	POSTTEST	DELAYED POSTTEST	PRETEST	POSTTEST	DELAYED POSTTEST	PRETEST	POSTTEST	DELAYED POSTTEST	
I	M	23.3	22.3	20.5	51.8	50.7	49.0	30.8	31.2	31.4	18.5	19.5	17.2	17.7	17.5	19.9	11
	SD	7.4	7.7	7.5	8.9	10.0	7.8	7.0	6.0	4.0	6.5	7.1	5.8	4.5	4.6	6.7	
II	M	24.4	23.9	24.4	50.5	52.4	52.1	30.9	34.9	35.0	19.0	19.5	16.4	16.4	17.0	19.0	11
	SD	8.8	6.3	8.6	8.3	7.2	6.7	5.4	4.4	3.2	6.9	6.3	7.4	6.3	8.8	5.0	
III	M	24.6	22.5	24.4	48.7	48.0	50.1	29.7	31.4	33.3	19.9	17.9	19.8	18.8	20.3	21.0	12
	SD	10.3	8.9	9.7	5.0	9.8	8.5	15.0	3.8	2.7	9.5	5.8	8.3	6.2	3.3	2.7	
IV	M	20.8	22.1	21.9	51.5	47.6	49.0	32.8	32.3	32.5	15.5	17.1	16.9	13.2	17.0	15.8	11
	SD	7.8	8.5	8.3	4.4	5.4	5.3	4.9	3.6	4.5	7.8	6.9	6.3	3.2	5.0	4.6	

TABLE D-4

PRETEST, POSTTEST, DELAYED POST - ATWPS

MEANS AND STANDARD DEVIATIONS ON ALL LEVELS

Western Piedmont Community College

TREATMENT		WORK			PROFESSIONALS			# of Ss
LEVEL		PRETEST	POSTTEST	DELAYED POST	PRETEST	POSTTEST	DELAYED POST	
I	M	46.8	48.4	47.3	42.2	44.4	35.4	11
	SD	11.1	4.4	3.8	14.6	9.8	13.8	
II	M	47.9	44.9	43.2	44.2	37.3	32.2	11
	SD	5.8	8.0	6.8	14.0	13.7	10.2	
III	M	46.8	46.3	46.6	42.2	44.4	35.4	12
	SD	12.1	7.4	10.1	14.8	11.4	13.2	
IV	M	49.6	49.6	50.7	53.2	53.6	51.0	11
	SD	4.8	5.6	7.1	11.7	12.3	16.7	

TABLE D-5

MEAN SCORES RELATING 3 SELF CONCEPT GROUPS TO

5 OMI* FACTORS ON PRETEST, POSTTEST AND DELAYED POSTTEST

Wayne Community College

		C_1					C_2					C_3				
SELF CONCEPT	# of Ss	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E
HIGH POSITIVE	17	24.6	52.0	30.2	20.5	15.5	23.2	52.5	31.3	18.9	17.4	23.9	52.3	31.2	19.4	18.8
AVERAGE	18	28.3	50.4	31.7	18.4	14.6	26.0	50.3	30.9	20.2	15.7	24.6	53.9	32.6	20.0	14.4
LOW NEGATIVE	13	26.5	50.2	33.1	19.1	18.1	26.4	53.1	32.8	18.6	17.7	25.5	50.8	33.1	17.5	16.8

*Opinions About Mental Illness Scale

TABLE D-6

MEAN SCORES RELATING 3 SELF CONCEPT GROUPS TO

5 OMI* FACTORS ON PRETEST, POSTEST AND DELAYED POSTTEST

Western Piedmont Community College

		C_1					C_2					C_3				
SELF CONCEPT	# of S_s	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E
HIGH POSITIVE	14	19.4	53.4	31.4	17.0	13.6	20.3	52.8	32.4	15.9	15.4	20.9	46.3	42.6	52.0	32.7
AVERAGE	9	25.1	51.2	32.3	16.7	17.8	23.1	51.4	34.6	14.3	19.4	21.9	49.5	32.7	15.4	21.6
LOW NEGATIVE	22	25.0	48.5	30.4	20.2	17.9	24.0	46.9	31.5	19.3	19.1	24.5	49.0	33.4	18.7	18.6

*Opinions About Mental Illness Scale

APPENDIX E

Outlines of Treatment Programs:

Lectures and Booklet

Appendix E-1

POSITIVE APPROACH TO THE PSYCHIATRIC PATIENT

AND THE REHABILITATED PERSON

I. Definition and brief history of mental illness

II. Attitudes toward the mentally ill

- A. Public
- B. Employer
- C. Other

III. Public identification of the mentally ill

IV. Contact with the mentally ill

- A. Attempts of persons to hide contact with the mentally ill
- B. Denial of the mental illness of relatives and friends

V. The structure of social response to the mentally ill

VI. The nature of acceptance

- A. Elimination of punitive, judgmental, and rejecting attitudes
- B. Elimination of overcritical attitudes and unrealistic expectations
- C. Readiness to Help: Accentuating the Positive
  1. Desire to help
  2. Faith in people
  3. Capacity for honest thinking
  4. Courage to trust
  5. Sensitivity

Appendix E-2

COMMUNITY MENTAL HEALTH PROFESSIONALS AND PARAPROFESSIONALS*

I. Definition and Development

   A. Community Mental Health

   B. Paraprofessionals

   C. Professionals

II. Types and Characteristics of the Paraprofessional Population

   A. The Old Paraprofessional

   B. The New Paraprofessional

   C. The "Indigenous" Paraprofessional

   D. The Typical Paraprofessional

III. Selection, Formal Education, Training and Upgrading

   A. Selection

   B. Jobs and Upgrading

IV. Reasons for Using Paraprofessionals

   A. Importance

   B. Positive Results in Therapy

V. Relationship of Paraprofessionals and Professionals

   A. Functions Performed by Professionals and Paraprofessionals

   B. Advantages and Disadvantages of Using Paraprofessionals

   C. Resistance to Change by Professionals

   D. Importance of Paraprofessionals Having A Positive Attitude Toward Professionals--And Vice Versa

VI. Implications and Projections for the Future

*Outline of Lecture Given by Experimenter to Levels II and III

Appendix E-3

WHAT EVERYONE SHOULD KNOW ABOUT MENTAL ILLNESS*

I. Definition

A. Mental Health--Well Adjusted

B. Mentally Ill Person--Emotionally Disturbed

II. Facts--Americans

A. 1 Out of 3 Hospital Beds--Occupied by Mental Patients

B. 1 Out of 10 Americans Will Be Hospitalized During Lifetime

C. 1 Out of 10 Needs Treatment

D. More Than Half of People Who Visit Doctors--Etiology of Physical Complaints--Wholly or Partly Emotional

E. Mental Illness--Number 1 Social Problem

F. Mental Illness--Costs More Than All Other Conditions Combined

G. Persons Affected by Mental Health--Everyone

III. Etiology

A. Environment

B. Physical Causes

C. Heredity

IV. Symptoms

A. Anxiety

B. Depression

C. Sudden Change in Mood or Behavior

D. Physical Complaints--No Organic Cause

E. Poor Performance

*An outline of information from booklet given to Levels II and III

F. Tensions

1. Definitions

2. Results

a. Worry
b. Irritable
c. Doubtful
d. Shy and Timid
e. Suspicious
f. Dissatisfied
g. Over-Aggressive

3. Some Ways to Overcome

a. Talk It Out
b. Take One Step
c. Take It Easy
d. Get Away
e. Get Rid of Anger
f. Do Something

V. Three Common Patterns--Mental Illness

A. Neurosis

1. Definition

2. Characteristics

a. Anxieties
b. Phobias
c. Compulsions
d. Physical Complaints

B. Psychosis

1. Childhood Autism

2. Schizophrenia

3. Manic-Depressive

4. Cerebral Arteriosclerosis

5. Involutional

6. Senile Psychosis

C. "Character or Personality Problems"

1. Defects of conscience

2. Defects of judgment

3. Defects of relationships

VI. Treatment of Mental Illness

A. Milieu Therapy

B. Somatotherapy

C. Psychotherapy

1. Types

a. Group Therapy
b. Individual Therapy
c. Psychoanalysis

2. Location

a. Mental Hospitals
b. Mental Health Clinics
c. General Hospitals
d. Most Schools and Colleges

3. Personnel--Psychotherapists

a. Psychiatrists
b. Psychoanalysts
c. Clinical Psychologists
d. Psychiatric Social Workers
e. Team Approach

VII. Foundations and Important Factors in Good Mental Health

A. Infant Dependency

B. Pre-School Children Experiences

C. People Children Meet in School

D. College Years' Experience

E. Marriage Relationship

F. Job Experiences

G. Transitional Middle Years

H. Retirement Experiences

I. Golden Years' Dependency

VIII. Some Questions About Mental Health

A. Who Should Decide Treatment?

1. Doctor

2. Psychiatrist

3. Clergyman

4. Social Agency

5. Mental Health Center

B. What About Hospitalization?

1. Legal Requirements

2. General Hospitals

3. Consultation with Psychotherapist--Doctor, Clergyman, Mental Health Clinic

C. How Can A Person Help?

1. By Understanding

2. Re-Assurance in Strange Surroundings

3. When Patient Returns Home--Bolster "feelings of belongingness" and self confidence

IX. Responsibilities of Average Citizen

A. Know Something About Number 1 Social Problem (causes, treatment, etc.)

B. Utilization of Knowledge

1. To Fight Ignorance

2. To Fight Indifference

3. To Fight Poverty

4. To Fight Inaction

ADDRESS OF BOOKLET: A Scriptographic Booklet
Channing L. Bete, Inc.
Greenfield, Massachusetts, U.S.A.

Appendix E-4

THREE MODULES: COMMUNICATION STYLES, TRANSACTIONAL ANALYSIS, AND REALITY THERAPY

I. Module A--Communication Styles

A. Utilization of Communication Styles

1. Importance of Effective Communication With Others

a. Half World's Troubles Caused By Tone of Voice
b. Body Language--Straight Messages and Mixed Messages
c. Verbal Communication--Importance of Style

B. Effective Communication Results When:

1. We Speak For Self Rather Than Others

2. Make Feeling Statements When Speaking About Self

3. Document Words With Descriptive Behavioral Data

4. Make Intention Statements When Speaking About Self

C. Styles of Communication

1. Style I: Sociable, Playful, Everyday, Conventional

2. Style II: Directive, Persuasive, Assertive, Evaluative, Manipulative

3. Style III: Speculative, Searching, Intellectual, Serious But Safe

4. Style IV: Open, Penetrating, Elaborating, Serious With Risks

5. Role Playing--All Four Styles

II. Module B--Transactional Analysis

A. Composition and Development

1. Theory of Personality

2. Analysis of Social Interaction

3. Method of Clinical Psychology

4. Developed by Eric Berne

B. Some Definitions

1. Stroke

a. Definitions
(1) Any Act That Implies Recognition of Another Person's Presence
(2) Examples: Physical Contact, Exchange of Words, Gestures or Looks

b. Types of Strokes
(1) Positive
(2) Neutral
(3) Negative

c. Importance of Strokes
(1) Spines Will Swirl Up
(2) Negative Strokes Better Than None At All

C. Time Structuring to Avoid Boredom, Anxiety, or Similar Feelings

1. Ways To Structure Time

a. Ritual
b. Work
c. Pasttimes
d. Games

D. Warm Fuzzies and Cold Pricklies

1. Analogy of Positive Strokes

2. Counterfeit

E. Games

F. Ego States

1. Child

2. Parent

2. Adult

G. Life Positions

1. I'm OK--You're OK

2. I'm Not OK--You're Not OK

3. I'm OK--You're Not OK

4. I'm not OK--You're OK

H. Quadrants

1. Characteristics

a. State of Loving, Enjoyable, Healthy Interpersonal
b. Depressive Position--Can Be Suicidal--Out of Touch With Reality Psychotic
c. Criminal Or Psychopathic (Sociopathic) Position

2. Location--Determined by Experience

I. Transactions

1. Definitions

a. Stimulus By One Person
b. Response By Another

2. Rules of Communication

a. Transaction is Complimentary--Can Go On Indefinitely
b. Transaction is Crossed and Stops Communication When Stimulus and Response Line Crossed

3. Role Playing

a. Dyads
b. Group Members

4. Life Scripts

a. Dramatic Life Events
b. Important Forces--"Messages" Parents Send In

5. Examples of Messages

6. Exercises

a. Vocation
b. Education
c. Religion
d. Family Life
e. Mother/Father
f. Use of Time
g. Use of Money
h. Ethical/Moral Values
i. What Else Is Importance

J. Parable of The Eagle and The Chicken

1. Identify True Self

2. Don't Be "Chicken" If You Are An Eagle

III. Module C: Reality Therapy

A. Development

1. Author--William Glasser

2. Seeks to Help People Who Help Themselves

3. Used by Professionals and Paraprofessionals

4. Two Types of People

a. Those Who Are Getting Along
b. Those Who Are Not Getting Along

B. Successful vs. Non-Successful People

1. Successful

a. Strong (at particular time)
b. Can Cope
c. Handle the Situation
d. Potential Strength

2. Non-Successful

a. Weak
b. Can't Cope
c. Person is Helped to Increase Strength by Coping With Reality

C. Reasons Person Is Strong

1. Has Love

2. Has Sense of Personal Value

D. Reasons A Person Is Weak

1. Easier to Give Up

2. Pain if Reduced Only Temporarily

3. More Painful to Try and Lose

E. Alternatives to Pain

1. Drugs and Alcohol
2. Gambling
3. Overeating
4. Making Choices--Withstand Pain

F. Eight Principles of Reality Therapy

1. Make Friends
2. Ask the Person "What Are You Doing? Is This Helping?"
3. When They Say "No," Then Ask "What Could You Do?"
4. Get A Commitment (Contract)
5. Don't Punish
6. Never Give Up
7. No Excuses